

**A Research Evaluation of GROW,  
a Mutual Help Mental Health Organisation.**

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a Mutual Help Mental Health Organisation**

**by**

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I certify that this thesis contains no material which has been accepted for the award of any other higher degree or graduate diploma in any university, and that to the best of my knowledge and belief the thesis contains no copy or paraphrase of material previously published or written by another person, except where due reference is made in the text of the thesis.

A handwritten signature in black ink, appearing to read 'J.L. Young', with a stylized, cursive script.

**J.L. Young**

## ABSTRACT

GROW is a mutual help organisation founded in Sydney, Australia, in 1957 by former patients of mental hospitals as a direct response to their own experienced needs after they had been discharged from hospital. Initially established to assist psychiatric patients' rehabilitation into the community, the organisation soon broadened its aims to help members deal with any problems and to fill a preventative and educative role in the area of mental health so that many of its members now have never been diagnosed as mentally ill. The organisation adopted a pattern of meeting weekly and evolved a literature centred on the record of members' successful strategies.

Government and private funding were attracted and by 1985 GROW was established in every state and territory in Australia and in New Zealand, Ireland, the United States and Canada. In Australia public funding was by then almost \$1.5m per annum. Although this provided de facto recognition of GROW as a mental health service, because of its complexity no attempt had been made to measure the effectiveness of the organisation. With added competition for funding for community-based care of the mentally ill, pressure mounted for an objective evaluation.

This study examines, in three phases, GROW throughout Australia at the group and individual level. The first phase is a national survey to identify the personal and demographic characteristics of GROW

attenders, their reasons for attending, their use of medication and professional resources and their perception of the efficacy of the organisation. The second phase, with a sample of groups chosen to be representative of the national profile in the light of the first phase, examines the group climate and processes seen to be operating in the meetings. The pattern of member attendance is also determined. The third phase is a longitudinal study in which a sample of GROW members, again representative of the national profile, are interviewed on five occasions over at least twelve months to determine changes, if any, coincident with GROW attendance.

Ninety-one percent of GROW attenders nationwide responded to the phase one questionnaire. Two-thirds of members were female, approximately 65% were aged between 30 and 60 years, many reported limited social networks and felt that GROW contacts helped alleviate this situation. Most perceived GROW as helpful and they reported a decreased use of medication and professional help. Cluster analysis revealed a number of subtypes of GROW attenders: those with psychological/psychiatric symptoms; those with diminished social networks; those who had experienced traumatic life events; and those wanting to help others.

Phase two concluded that GROW groups are strongly cohesive with a firm leadership and a structured meeting pattern resistant to change. Groups encourage personal growth and personal change in a climate that avoids the expression of negative feelings and

confrontation. Over a 13 week period, nearly one third of a representative sample attended one meeting only, one third attended at least half the meetings and 9.4% attended all the weekly meetings. The average attendance at each group was between five and six members.

Phase 3 involved four interviews over six months and one follow-up interview at least six months later with 102 GROW members. Ninety-four percent of possible interviews were completed and contributed to the results. The study concluded that attendance at GROW was related to a perceived improvement in many aspects of members' lives, improved quality of friendships and a decrease in symptomatology. Comparison with a non-equivalent control sample and comparison between regular and irregular GROW attenders strengthened this conclusion.

The implications of the conclusions for mental health services are discussed and suggestions for further research explored.

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## **CHAPTER 1**

### **INTRODUCTION TO THE INVESTIGATION**

GROW is a mutual help organisation founded by former patients of mental hospitals in response to their own experienced needs after they had been discharged from hospital. As such it can be seen as a direct link in an historical chain of events which has resulted in a fundamental shift in the treatment of mental illness from institutions to the community.

### **1.1 Deinstitutionalisation**

During the first half of the nineteenth century there was recognition that restraint of the mentally ill was not all that could be done for the relief of suffering, a recognition which gave birth to the provision of mental hospitals supported by the state. However, failure of adequate funding and staffing over the first half of this century together with public perception of state mental institutions as a location for communities' difficult members saw mental hospitals in Australia as in the United States, become "vast storehouses of some of the most disabled and miserable people in the country" (Bloom, 1977, p.10).

By the end of World War II the view was virtually universal in western countries that the mentally ill are best treated in an environment that permits contact with the rest of society and access to mainstream institutions, demands independent functioning, is relatively non-coercive and encourages contact with family members (Okin, 1985). In other words, patients expecting ultimately to live in the community can best learn the skills they need by being there.

Growing dissatisfaction with the public mental hospital system as the prime channel for service delivery in the treatment of mental illness coincided with spectacular advances in psychopharmacology (Baldessarini, 1977). This did not mean that mental illness was suddenly no longer a problem. Medicated patients were still often seriously disabled but, for the first time, people who might have presented a danger to themselves or others were able to be discharged with little danger into the community. Authorities with an interest in the allocation of funds saw an immediate advantage: no longer need hundreds of people be a charge on the public purse and a huge boost to the process of deinstitutionalisation was assured (Bloom, 1977).

Unfortunately the accountants' dreams were justified and patients were discharged, their more florid symptoms controlled by continued medication but often still very disturbed, with little hope of fitting into the life from which they had come and no provision for their further treatment or rehabilitation. Economically it was something of an immediate success but in most other ways, a disaster (Torrey, 1987).

The assumption was made that the existing public health system and community health clinics would cater for the needs of the chronically ill once they had been discharged and that the discharged patients would be willing and able to use those services. In practice this assumption proved to be ill-founded: patients were frequently too disabled to be able to negotiate the complexity of the community system and, further, one of the symptoms of their illness was often a lack of

insight into their need for continued medication. Arguing for assertive provision of community based services, Test observed: "Chronically mentally ill persons often have a high vulnerability to stress, poor interpersonal skills, low motivation, and passivity and extreme dependency. Persons with these characteristics often fail to get services because to do so requires a certain level of motivation and interest in participation" (Test, 1981, p.80).

That might not have been an insurmountable problem had the discharged patients had an adequate network of friends and family to assist them (Estroff, 1981). But usually they did not. Generally public attitudes to the mentally ill were even less well-informed in the 1950s than they are today and those who had been in mental institutions were stigmatised and shunned (Bevan, 1982). Families from whom they had been separated during their hospitalisation were not equipped by understanding or resources to deal with the difficulties their discharged relatives faced and, in any event, those relationships had frequently been damaged in events surrounding the first stages of their illness (Helmersen, 1983).

Again it is a common symptom of a range of serious mental illnesses that interpersonal relationships are a major difficulty (Davison & Neale, 1990). Mentally ill people find it difficult to get to know others, to trust them or to share with them. Such disabilities have been shown frequently to be compounded by the impact of rigid institutional life, extinguishing adaptive behaviours they may have

retained (Ullman & Krasner, 1975). Within the hospital system, structured and predictable as it was, many patients had been able to set up limited but functional relationships; in the far less structured community into which they were discharged such relationships were beyond the capacity of many (Gartner & Reissman, 1982). They were deprived by deinstitutionalisation of the friendships with staff members on which they had relied, and the associations they had established with fellow patients were frequently disrupted.

In hindsight it seems incredible that these assumptions were made. In 1981, Scull, discussing the rights of the mentally ill to treatment within the community, observed that "For all the high-flown phrases and occasionally moderately successful pilot program, the realities of life for the decarcerated patient are all too often exceedingly grim" (Scull, 1981, p.14). Reviewing the process of deinstitutionalisation, Talbot (1979, p.622) suggested that "To expect patients with major ego deficits and residual dysfunctioning, without families and social networks, to suddenly be able to obtain for themselves the professional and custodial services they formerly took for granted in total institutions seems the stuff of sheer fantasy".

## **1.2 GROW's Foundation**

It was in this context that GROW was established. A number of people, all of whom had been hospitalised for serious mental illness and who had been discharged, met while attending meetings of

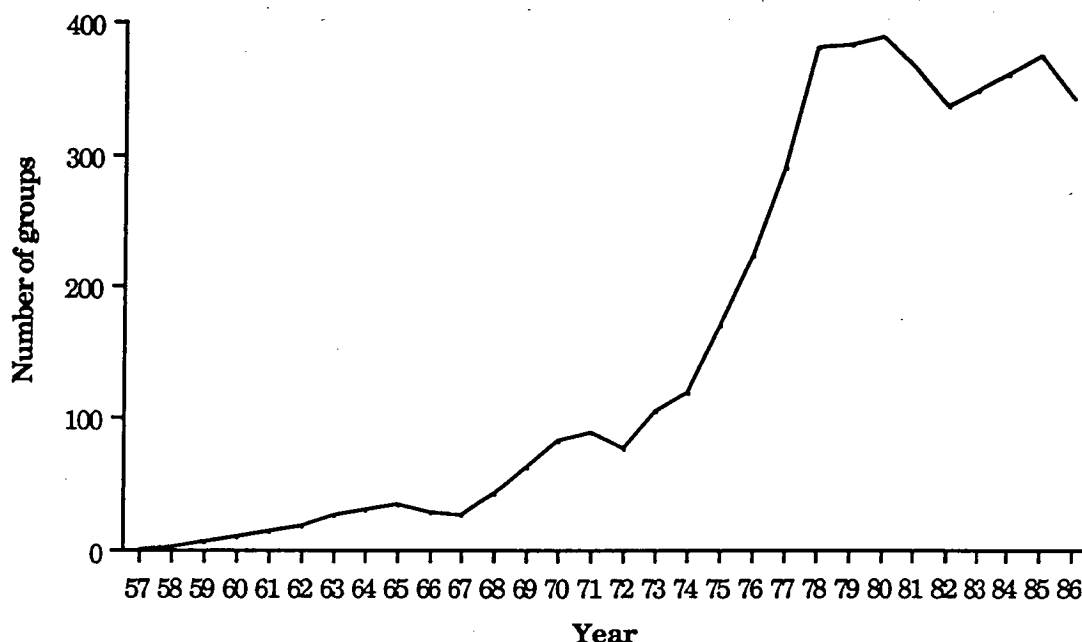
Alcoholics Anonymous (AA) in Hurstville, a suburb of Sydney, New South Wales in 1957. Their common purpose in attending AA was to find friendship. Usually heavily medicated, their behaviour often unusual, on discharge from hospital they had frequently found that the friends they had had before their illness, and sometimes their families, did not want to know them. But at AA they found acceptance: they did not have to explain their "lost" years and their sometimes strange behaviour was not a reason for rejection (Sprague, 1979).

The AA programme, however, was not appropriate to their needs. Alcoholism was not for most of them a problem, or at least not a primary problem. So the former psychiatric patients started to meet at first during the week between AA meetings and later weekly instead of the AA meetings. The fledgling organisation started at once recording those things that they found useful to their rehabilitation and acceptance by society. They became aware, by chance, of some of the writings of Dr Abraham Low, (Low, 1950), founder of Recovery Inc. in Chicago and, without making contact with the American organisation adopted the name "Recovery" as well as some of the ideas and phrases from Recovery Inc's literature (Sprague, 1979).

In 1957 one GROW group (as Recovery) started meeting informally. In 1961 the organisation was registered, by the end of 1962 expansion had gone beyond New South Wales into Queensland and in 1964 into Victoria and South Australia. During the 1970s the expansion was very rapid (Fig 1); the name was changed from Recovery to GROW (Keogh &



Lacey, 1979) and by 1978 GROW was established in every state and the Australian Capital Territory, and, five years later, in the Northern Territory as well.



**Figure 1: The expansion of GROW in Australia, between founding in 1957 and 1986.**

### 1.3 Public Funding

Workers in the health services area, alerted by overseas experience and by the expressions of fear and concern by citizens in general about the discharged mentally ill (Scherl & Macht, 1979) saw GROW as one of the few organisations providing support in the community and were quick to sponsor submissions for financial grants from private benefactors and from government sources. In 1965 the first government grant (in NSW) was given to GROW to open a centre and to employ a fieldworker and state grants from other states followed, with

grants from the federal government to support a national secretariat from 1975.

As the organisation expanded, so did the funding. In the early 1970s funding through the social programme funding of the federal government was generous and by 1986, when 398 groups were meeting throughout Australia, funding had been attracted from each state and from the federal government totalling more than \$1,500,000 with other income of \$351,000 (GROW, 1986).

At that time no formal evaluation, organisationally or in terms of outcome, had been undertaken. GROW employed 40 full-time and 13 part time staff (GROW, 1986) and, not only was a large amount of money, from government and non-government sources, being expended but it was claimed that many people were being involved as leaders and in membership. Indeed it was established that GROW had significant contact with at least 5000 individuals in a year and about 80,000 meeting/attendances a year (i.e. at least 160,000 contact hours apart from contact between weekly meetings, at social functions and at the frequently-held residential weekends) (Young, 1990b). Anecdotal accounts of the benefits of participation abounded, but what the characteristics of the members were, why they attended and what benefit, if any, they derived from attendance had never been assessed. This is the object of the present study.

## **CHAPTER 2**

### **THE MUTUAL HELP MOVEMENT**

## 2.1 Definition

The banding together of people who share a common condition or life circumstance which they would like to change, working together to overcome difficulties they experience and they themselves, those directly affected, controlling the activities and priorities of the group, (COSHG, 1982) delineates a unique type of organisation which has in last 25 years become a significant factor in health, welfare and the social services (Borkman, 1990). This is the self-help movement.

Though self-help is the popular appellation for the type of organisation, literally "mutual self-help" is a more accurate description: help to change is dependent upon the individual's decision and action, but always in the context of others, also in the process of change. For the purposes of this thesis, the more convenient (though less precise) term "mutual help" has been adopted to refer to that class of organisations defined above, including to GROW, the subject of this study.

Informally mutual help is an apt description for much of the human interaction since the dawn of society and mutual help organisation beyond the family is certainly not a new phenomenon. Though the influence of such organisation has never been as widespread as in recent years, it has made some important contributions to social development in other ages. Its lineage can be traced either from religious organisation in the Judeo-Christian

tradition (Hurvitz, 1976; Oden, 1972) or through the development of occupational guilds and the union movement (Katz & Bender, 1976), but nowhere is a coming together of these traditions clearer than in mutual help groups which have had as their purpose the alleviation of the stigma associated with mental illness and the provision of support and contribution toward the members' psychotherapy and psychosocial rehabilitation.

## **2.2 Recent Developments**

The proliferation of mutual help groups, particularly in the area of mental health was a feature of the 1970s which has continued with considerable force in Australia, as in other countries, throughout the 80s.

The movement has paralleled and reflected a more general social movement toward consumer involvement in a wide range of activities including education, the provision of social amenities and services, the shaping of welfare structures and their political infrastructure and the treatment and rehabilitation of the ill and handicapped.

The reasons for this movement are no doubt diverse and complex but coincident with it are numbers of developments which may have had an influence.

First there has been the widespread perception that institutions which had been relied upon to provide care for the helpless and support for those in need were failing (Rappaport, 1977).

Secondly, professional help in matters of personal psychological and medical concern has been viewed more critically and alternatives have been increasingly sought (Illich, 1976).

Thirdly, there has been a convergence, in fields of psychology, sociology, education and medicine, of professional recognition of the value of the participation of the consumer in contributing to his own recovery or advancement (Katz & Bender, 1976).

Fourthly, there has been a popularisation of the understanding of group dynamics and increasing perception of small groups as the means of personal growth (Schultz, 1971).

And fifthly, there has been a new sense of immediacy and involvement in all manner of endeavours coincident with almost universal exposure to the influence of television (Toffler, 1980).

These factors have had influence in all types of mutual help group (Levy, 1979), but the expansion of the movement in the area of mental health has coincided with an acceleration of the process of deinstitutionalisation.

## 2.3 Theoretical Perspectives

Development of mutual help groups in the area of mental health was often an immediate response to the experienced needs of people who had been discharged from mental hospitals with little provision for their support or ongoing treatment.

Describing prospective members of mutual help groups in general, Levine and Perkins (1987) noted that they interpret their problem as a departure from a normative ideal: for former patients of mental hospitals, their need was to fit the criteria of behaviour to be accepted as members of the community into which they had been discharged (Sprague, 1979). Levine and Perkins observe that "[prospective mutual help group members'] difficulties are often exacerbated because the ordinary agencies of assistance have proved insufficient, inadequate or even punitive. As a consequence the individual will not have developed a philosophy for viewing the problem, nor had the opportunity to learn, directly or vicariously, useful strategies for coping with the myriad of everyday issues related to the core problem"(p.242).

Meeting for mutual support and to map a way in which they could cope with the pressures of living in a community which they often perceived as being hostile, people discharged from mental hospitals approached their common problems pragmatically (Lieberman & Borman, 1979). Programmes for rehabilitation they developed often consisted of a documentation of behaviour they found successful in

integrating them into society and what they found it helpful to avoid. Consequently, the theoretical background of the mental health mutual help movement is sparse.

A number of generalised theoretical explanations of the movement's apparent success have, however, been proposed.

One of the most comprehensive theoretical explanations of mutual help groups has been provided by Thomasina Borkman (1979, 1984) who suggested that such groups are to be understood as a means of sharing experiential knowledge (distinguished from folk knowledge) and its use for problem solving. Mutual help groups are also the means by which the selective unsupportiveness of members' personal and community social networks are supplemented and reconstructed (Borkman, 1984).

While the theory has apparent descriptive validity for a wide range of groups it does not bear on the distinctive mutually shared leadership and decision-making characteristic of the organisational structure of such groups.

Another perspective is provided by the theory of Paul Antze, (1976, 1979) who examined the role of mutual help organisations' implicit ideologies and concluded that the ideology adopted provided a "cognitive antidote" for beliefs which underlie members' problems. Alcoholics Anonymous, (AA), one of Antze's examples, urges members to surrender to a higher power (God) because the plight of alcoholics is



due fundamentally to the (mistaken) belief that they can control their drinking (Alcoholics Anonymous, 1955). Recovery Inc., another example Antze cites, is comprised of former mental patients whose experience has been that their lives seemed somehow to have been out of their own control, and central to their ideology is the concept of the individual's will which can be used to control or overcome symptoms (Low, 1950). Thus AA urges members to admit their powerlessness and need of help: Recovery urges its members to assert themselves in controlling their lives.

Though persuasive with the examples Antze cited, it is difficult to see how his theory can be applied comprehensively. Many groups are unsophisticated in their beliefs and practices and the association of members seems more to be for common support and for the effective pursuit of their own special interests. For example, Overeaters Anonymous, (OA), though sharing with AA the expressed belief that members' lives are out of control, does not appear to make belief in a higher power a central tenet of its ideology. Rather, in the words of Goldner (1984, p.71), "[OA] depends, ultimately, upon an ideological consensus about the purposes of meeting together, and by implication, about the purposes of the organisation as a whole. Here the OA literature is absolutely explicit -- 'OA exists for the sole purpose of helping its members abstain from compulsive overeating and to carry its message to other compulsive eaters who still suffer'". Here, as in many mutual help groups, ideological concerns are subsumed by a single-minded shared objective.

Extending Antze's emphasis on the importance of ideology, Suler (1984) maintained that even in organisations where no ideological position could be inferred, the "core ideology intrinsic to the mutual-aid movement" (p.30) provides the key to therapeutic function. The word "self-help", he suggests, connotes "egalitarianism, grass-roots decision making and the ability to change oneself by one's own efforts"(p.30). This orientation, reinforced by members' commitment to help each other, (shifting between the client and therapist roles), provides a philosophy of group support enabling people to overcome a sense of powerlessness and to use their own strengths.

An organisational theory of mutual help groups proposed by Medvene (1985) paralleled that of Antze and Suler in that the strength of a group and its effectiveness was held to be dependent upon factors other than the explicit content of the groups' programme. Medvene suggested that organisational infrastructures of helping roles are related to accomplishment of the group's objectives and that effectiveness is to be understood in terms of the appropriateness of such infrastructures.

Medvene's focus on the organisational aspects of groups discounts the programme content which many groups, particularly those having behaviour change as a goal, accumulate. In this respect his theory is complementary to that of Borkman (1984).

Yet another theory has been put forward by Arno van der Avort (1985). He proposed that mutual help groups are to be understood in terms of identification resonance: that group members by sharing their feelings and experiences surrounding common problems gain new insight when personal associations form the echo or "resonance" of mutual identification. Values of self-determination, authenticity, hope and solidarity play a primary role, van der Avort suggests, in providing the basis for therapeutic use of identification resonance.

The theory goes further than others in suggesting that mutuality provides a dynamic not available in other groupings, but the idea awaits substantial empirical support.

A different approach again has been provided by Leon Levy (1976, 1979) who proposed a theory grounded in an examination of the processes and procedures of the mutual help groups' operation; in fact a theoretical conceptualisation of the psychological processes operating in the groups. Killilea (1976) has also identified a number of psychological theories which find expression in the operation of mutual help groups. In sum they may be said to provide an explicative description of mutual help groups, but clearly such psychological theories, developed apart from the mutual help movement, do not embody any unified theory exclusive to that movement.

The power of mutual help groups has been identified by Gartner and Reissman (1982) as residing in a number of properties which most such

groups share: the helper-therapy principle (Reissman, 1965), group reinforcement, continuity of intervention, a shared ideological perspective, an implicit demand that individuals act for themselves and the provision of an enhanced sense of power and control in their own lives. Of these properties Gartner and Reissman emphasised the helper principle as the most significant -- "in its simplest form...those who help are helped most" (1982, p.633). In a more recent paper (1990) Reissman enlarged on the principle and identified reasons for the power, as he saw it, of the helping role.

A list of six significant aspects of mutual help groups identified by Levine and Perkins (1987) overlap the properties identified by Gartner and Reissman. "Self-help groups:(1) promote the psychological sense of community; (2) provide an ideology that serves as a philosophical antidote; (3) provide an opportunity for confession, catharsis and mutual criticism; (4) provide role models; (5) teach effective coping strategies for day-to-day problems; and (6) provide a network of social relationships." (p.243).

On this basis, Levine proposed a "theory of support and personal change" (Levine, 1988,p.178).

"Changes in feelings, attitudes, and behavior will occur when the individual internalizes and uses a socially shared ideology that offers a useful interpretation of the person's situation. Conditions that enhance identification with others who espouse the ideology

will enhance internalization of the ideology. When one internalizes an ideology and lives up to its tenets, self-esteem is enhanced."

Greater mastery of and facility with a mutual assistance group's ideology and language will be correlated with greater personal change and improved adaptation. Those who are accepted as role models will have greater facility with the ideology than those who are not pointed out by others as examples of the success of the program.

The ideology, learned in a social context, has the property of reducing isolation. In fact, the shared ideology and language are signs of mutual identification and the possession of a common culture. The adoption of the ideology in a context of mutual obligation may be a precondition for giving and receiving effective emotional and instrumental support. Help offered by one member to another may be more potent in reducing distress than help offered by a nonmember.

Through the process of concept formation, the individual gains a basis for categorizing a new experience and then for using the actions the ideology correlates with the category to which the new experience has been assigned. Conditions that permit the individual to articulate ideology by assigning ideologically derived labels to many concrete experiences will enhance the power of the concepts making up the ideology to direct everyday choices. Mutual

assistance in face-to-face groups may be more effective than help coming from a self-help manual because of the greater opportunity to apply the terms of the ideology to examples of behavior provided by other members.... Increasing use of the ideology in more and more sectors of life experience will be correlated with better adaptation." (pp.178-179).

## **2.4 Application of Theories to GROW**

The theories cited above are not mutually exclusive and each may provide a contribution to an understanding of GROW.

The experiential knowledge to which Borkman (1979, 1984) referred has been made explicit in GROW's extensive original literature (Sprague, 1979, p.103); new supportive networks of members are consistently provided (GROW's "caring and sharing community") (GROW, 1983, p.1) and restructuring of dysfunctional networks is encouraged: "The healing of unhappy relationships may sometimes come about simply through improved communication. More often, perhaps, one or both of the persons may need to become stronger, wiser or more loving in other relationships first." (p.19).

An aspect of this investigation will be to examine the extent and importance of the social support GROW provides and the processes by which it is provided.

The two examples of the application of Antze's theory stand astride GROW's position. While the experience of GROW members, like that of Recovery Inc. members, is that their lives have been out of control and that they became "prey to obsessions, delusions and hallucinations" (GROW, 1983 p.4), they understand this to be due in part to their failure to co-operate with help, including "surrender to the healing power of God" (p. 5). Thus GROW members' active acknowledgement of their need, co-operation with help, and learning are necessary steps toward their surrender to God and their growth "daily closer to maturity" (p.5). For GROW, in Antze's terms, the cognitive antidote to lives seen to be out of control is to "train [their] wills to govern their feelings"(p.5): the cognitive antidote to growing "inattentive to God's presence and providence" (p.4), is to "surrender to the healing power of God" (p.5). GROW's description of itself as a "popular school of life and leadership for mental health" (p.1) is a clear claim to provide an ideological position to which its membership may subscribe; in fact throughout the members' handbook (GROW, 1983) but particularly in the latter half (pp.42-76), philosophical statements of belief derived from the movement's membership, abound. Members are invited, after attending at least three meetings, to make a commitment each week (p.77) to adopt this ideology and, in Suler's words, "The ideology becomes a new way of living, with the transition to the group's philosophy resembling a religious conversion..." (Suler, 1984, p.30).

Another objective of this study will be to gauge how central acceptance of the programme's philosophy is in GROW, how this

impinges on behavioural processes of learning, training and taking control, and to what extent religious belief and practice plays a part.



The organisational infrastructure which provides for leadership roles within a member's first three meetings, roles for each member as help-seeker and help-giver and by "undermanning" (Zimmerman, 1987) can be appreciated in terms of Mendvane's organisational theory. Undermanning refers to an organisational setting which has more roles than individuals to fill them, a situation which strongly encourages active participation by members, develops a sense of importance in new members and a sense of connectedness to the organisation. Thus GROW's organisational infrastructure makes possible, and in some instances unavoidable, an experience of empowerment attuned also to GROW's objective of growth toward maturity: "The more maladjusted I am the more I need help, yet to grow out of maladjustment I need to become concerned for and to be helping others" (GROW, 1983, p.7). The relevance of Reissman's helper-therapy principle (Reissman, 1965) to this aspect of GROW is clear.

Leadership exercised by GROW members and their perception of the quality of the leadership of others will be another aspect to be studied in the present investigation.

Identification to which van der Avort's theory of identification resonance refers is a prominent feature of every GROW meeting. Members, as they experience help from their participation in GROW are encouraged to develop a statement of their particular problem, the way in which they have been helped and the particular features of the

GROW program which relate to their achievement. This "personal testimony" (GROW 1982, p.2) then becomes a resource which is available for use near the start of any meeting and it is attested by many members (Sprague, 1979; Keogh, 1975) that identification with such an account has been the starting point of their personal growth.

The part identification plays in GROW's processes and the use of role models will be examined as part of this study.

Processes which reflect a number of theories of behaviour change have been referred to by Levy (1979) and Killilea (1976) and elements of many can be demonstrated in GROW's program. In this respect GROW's practices would seem to have anticipated or at least paralleled the evolution of the behavioural and cognitive-behavioural movements in psychotherapy.

For example, GROW's explicit reference to "learning to think by reason rather than feelings and imagination" (GROW, 1983 p.5) suggests a link with Beck's cognitive therapy (Beck, 1976) and Ellis' rational restructuring theory which underlies his system of Rational Emotive Therapy (Ellis, 1970). In a style reminiscent of Meichenbaum's self-instructional training, (Meichenbaum, 1977), GROW members are encouraged to learn verbatim and to repeat in a question-and-answer session at each meeting self-directed instructions: e.g. "Never say 'I can't' if the thing in questions is an ordinary and a good thing. Do the ordinary thing you fear; do the

ordinary thing that repels you" (GROW, 1983 p.32). From each meeting GROW members are encouraged to undertake a "practical task" (GROW, 1982), a procedure closely aligned with the assignment of between-sessions homework common in most behavioural and cognitive psychotherapy. Rehearsal ("Remember that free wills become strong wills only through acquired habits -- that is, the repetition of many acts, and time") (GROW, 1983 p.32) and shaping ("If a thing is worth doing, it's worth doing badly -- for a start, and while you're improving." p. 33) are procedures with roots in behaviour modification (Wilson and O'Leary, 1980; Meichenbaum, 1977; Emmelkamp, 1985).

With its central concept of a shared ideology, Levine's theory, (Levine, 1988) encompasses many of the specifics referred to in earlier theories. The mutuality of support on which the theory is based is, historically and in current practice, a distinguishing feature of GROW and it provides a direction to this investigation. However, as Levine pointed out, "a general statement of ideology will not do" (p.179) for the testing of his theory, and a descriptive explication must provide the basis of particular measures.

## **2.5 A Grounded Theory for GROW**

Glaser and Strauss (1967) have proposed a process of generating theory systematically from the data of social research: "the discovery of grounded theory"(p.1). In such a process generating theory goes hand in hand with verifying it and the theory is discovered as the data are

obtained and analysed. Grounded theory is contrasted with theory logically deduced and since GROW in its inception had no clear theoretical base, it is contended that the development of grounded theory is an appropriate process.

To anticipate, the grounded theory is proposed for GROW, as an example of mutual help groups, that desired changes in the lives of its members are achieved through a complex interaction within a small group setting which allows the pooling of experience, the mutual recognition of salient features of each other's problems and solutions to those problems. The environment, enhanced by the small groups' membership of a larger organisation, provides an accepting, family-like and intimate support which encourages change and mutual responsibility according to an agreed explicit set of values. A sense of belonging is strengthened by a structured, ritualistic meeting pattern and the use of distinctive GROW linguistic style. Empowerment engendered by the expectation and provision of opportunity for each member to be a helper as well as being helped, enables the use of behavioural processes documented in the organisation's literature.

The result of the processes implied by this theory could be expected to be GROW members' improved satisfaction with their lives, if not symptomatic relief, and an enhanced sense of control in their lives' events. Some of these aspects will be addressed in this investigation.

## **CHAPTER 3**

### **GROW'S FOUNDATION AND DEVELOPMENT**

### 3.1 Factors Contributing to Permanence

Although GROW's immediate antecedent was AA, the organisation was also one of the first modern entrants in a much wider movement. Frequently, the existence of such groups is transitory (Borman, 1979; Leventhal, Maton & Madara, 1988). Many groups organised by people drawn together by a common problem, perform vigorously for a time and then, as circumstances of the members change, cease to function effectively and are disbanded or perhaps abandoned. In 1982 the Collective of Self Help Groups (COSGH, 1984) in Melbourne published a directory containing the names and addresses of 320 groups in the state of Victoria. In 1984 a new edition of the directory was published with 422 groups listed, but that figure did not include 107 which had not responded to requests for information at the new press date. Thus, although there was a net increase in the numbers of organised groups of 32%, 33% of groups listed two years previously were not responding to attempts to contact them. Leventhal, Maton and Madara (1988) studying all the mutual help groups in New Jersey at a similar time noted an annual group "birthrate" of 16% and an annual group "mortality" rate of 7.6%, a net increase of 8.4%.

A factor which may predict the longevity of a group organisation may be the means by which it was founded. Borman (1979) surveyed 10 established self help groups and found that in all of the organisations, which had been in operation for three years or more, he could identify one or more key professionals who had played an essential role in the founding or development of the groups.

In this respect GROW is no exception. One of the founding members was Cornelius Keogh, a highly literate and articulate Roman Catholic priest, who undertook the role of scribe and authored a number of the books which have become the foundation of the organisation's extensive literature. His style is reflected in the distinctive language which marks most of GROW's writings and the special quality of the language used (GROW, 1989, p.30) may act as a unifying force: a member's solidarity with the group is marked by his or her use of the jargon (Antze, 1979; Levine & Perkins, 1987).

It should be noted, however, that though Fr Keogh's editorial style is dominant in published literature, personal authorship is specifically denied. The process is described in Sprague (1979, p.103):

"You may ask: how did this Program come about? How did it evolve? From the very first Recover [i.e.GROW] meeting, the Recoverers resolved to meet again on another night of the week. At this meeting they decided they would not discuss their problems, but that they would reflect on the gains of the problem-solving meeting and record what they'd learnt that had proved successful or at least helpful. These two different kind of meetings have continued over the years: weekly problem-solving or personal growth meetings, and monthly 'leaders' meetings', as they came to be called. It is from the leaders' meetings -- recruited from those group members who have progressed far enough to conduct the local group meeting -- that the whole GROW Program has been produced, and, in fact, is still being produced."

The Program of Growth to Maturity (1983), the principle manual of the groups, first published in 1957 and revised four times, is specific and detailed and uses a phraseology designed to be memorized and used in GROW exclusively. In a separate publication (GROW, 1982), the weekly meeting's form and sequence is prescribed in great detail and emphasis is placed on the importance of adherence to the exact pattern. A detailed organisational structure, the GROW Schema, has been devised with the help of Dr Albert Lacey, (a lawyer and academic) who has been associated with the movement since the early 1960s. The schema defines the relationship among groups, lines of communication and central, regional and staff authority and responsibility (personal communication with C.B.Keogh, 1989).

### **3.2 Interstate and International Expansion**

After six years of expansion from one group to 23 within the state in which it was founded, the organisation spread, as members moved, to other States in Australia and overseas to Hawaii, New Zealand, Ireland and Singapore. Within Australia expansion was to South Australia and Victoria in 1963, to Queensland in 1969, Western Australia in 1971, Tasmania in 1978 and the Northern Territory in 1983. As noted earlier, the expansion is illustrated in Figure 1.

The spread of the movement was at first largely by "seeding" through those who had been involved in the organisation in New South Wales. When the opportunity arose, however, GROW leaders



encouraged and supported the expansion not only in Australia but overseas, and in 1978 Fr Keogh and Dr Lacey took deliberate steps to start groups in Illinois in the United States of America.

Although the input of Fr Keogh and Dr Lacey has been a critical factor in the continuing development and expansion of GROW and other people with professional qualifications have had some significant input from time to time, the organisation has also clearly rejected what it has seen as health professionals' efforts at what Mowrer (1979) called "co-optation" (the infiltration and ultimate control of the organisation) and has often been critical of psychiatric and medical treatment (e.g. Sprague, 1979, p.14; GROW, 1983, p.20).

The continued existence of the organisation inevitably brought about changes in the organisation itself. A group in which all members are at a similar stage in a process of change might be expected to have a different climate from a group in which there are members of long experience and members who have recently joined. Borman (1979) has noted changes in the nature of membership which have taken place in some groups: other more subtle changes are also likely to occur.

In the mid 1970s the name Recovery was dropped in recognition of the fact that many of the members were people who had experienced or were experiencing some serious difficulty in their lives but had never been diagnosed as mentally ill. The movement chose as its new name, GROW (Sprague, 1979, pp.78-79).

However, the early-established principle in the organisation of retaining written record of groups' findings and the refinement of such writings for use in future meetings has resulted in a body of literature which has assured a continuity and uniformity of process and structure over time and across Australia.

### **3.3 Programme Principles**

An early piece of literature which, with only minor modification, has been retained to the present is the "Twelve Steps of Personal Growth" (a reflection of the early close association with AA which has its own "Twelve Steps"). The twelve steps are read at each group meeting and, in a sense, set the agenda for the GROW programme.

#### **"The Twelve Steps of Personal Growth**

1. We admitted we were inadequate or maladjusted to life.
2. We co-operated with help.
3. We surrendered to the healing power of God.
4. We made personal inventory and accepted ourselves.
5. We made moral inventory and cleaned out our hearts.
6. We endured until cured.
7. We took care and control of our bodies.
8. We learned to think by reason rather than by feelings and imagination.
9. We trained our wills to govern our feelings.

10. We took our responsible and caring place in society.
  11. We grew daily closer to maturity.
  12. We carried the GROW message to others in need"
- (GROW, 1983, p.5).

Contrasted with this agenda is a list of "Twelve Stages of Decline", again one of the first items of GROW literature:

- "1. We gave too much importance to ourselves and our feelings.
2. We grew inattentive to God's presence and providence and God's natural order in our lives.
3. We let competitive motives, in our dealings with others, prevail over our common personal welfare.
4. We expressed or suppressed certain feelings against the better judgement of conscience or sound advice.
5. We began thinking in isolation from others, following feelings and imagination instead of reason.
6. We neglected the care and control of our bodies.
7. We avoided recognising our personal decline and shrank from the task of changing.
8. We systematically disguised in our imaginations the real nature of our unhealthy conduct.
9. We became prey to obsessions, delusions and hallucinations.
10. We practiced irrational habits, under elated feelings of irresponsibility or despairing feelings of inability or compulsion.
11. We rejected advice and refused to co-operate with help.
12. We lost all insight into our condition"(p.4).

Together these two sets of "twelve steps" provide a summary of the theoretical understanding underpinning the GROW programme and the GROW understanding of mental illness, (or, to use GROW's term, breakdown), and recovery. This is that breakdown occurs when an individual isolates him/herself, bases his/her behaviour on feelings or imagination rather than rational decision, refuses the advice or help of others and ignores the power of God. Recovery depends upon the reversal of these processes and persistence in rational behaviour through the use of personal and social resources.

### **3.4 Causal Theory**

Though the implication would appear to be a behavioural theory of the cause of mental illness, other factors are recognised as being significant: the GROW literature recognises "four great causes which influence our personal life and health: 1. Nature (heredity or constitution); 2. Nurture (society or culture); 3. Personal action, and 4. God (the overall cause)"(GROW, 1983 p.44). The section continues: "We believe that in the past untold harm has been done to people through onesided, incomplete and distorted views of the causes at work on them. Consequently, in the GROW movement we aim to keep the whole picture in view and to promote a whole work. In other words, while doing the part that depends mainly on ourselves -- self-activation through mutual help -- we seek to co-ordinate our efforts with those of other helpers in the community who know more about the other causes than we do (notably doctors, ministers of religion, educators and social workers)."

The emphasis of the GROW program from its inception has been on recovery, ("...mental health is the goal of the GROW program") (GROW, 1983, p.6), and members have avoided as far as possible speculation or theorising about causation. The "Principle of Responsibility" states: "However I came to be sick, it is my responsibility to get well...[it is] wrong to hark back to past causes to excuse present inactivity and unwillingness to change, wrong to stay sick when I can learn to get well, and wrong not to accept necessary help" (p.25). Discussing the relationship of GROW members and doctors, the program says: "Members...are urged to obey carefully their doctor's instructions" and "Matters pertaining to diagnosis and treatment, and technical language from psychiatry are banned from GROW group discussions"(p.20).

In summary, GROW sees the movement's processes and the application of its program as a partial, though major, contribution to the recovery and rehabilitation of its members. It was on this basis that GROW sought and received substantial financial support from state and private sources.

Two other aspects of GROW's practical functioning are also understood to be fundamental. These are referred to as the "group method" and the "caring and sharing community".

### 3.5 Group Meeting Pattern

The group method refers to a highly structured, ritualised meeting pattern which is followed with little variation for meetings of each group each week. Although it is understood to have been evolved by a pragmatic process, it operationalises significant dynamic principles (Hare, 1976; Heron, 1989).

Meetings are limited to no more than 15 and no fewer than three members. Each meeting is led by a member who has attended at least three meetings, appointed by the Organiser (annually-elected by group members) (GROW, 1989). The meeting starts with the leader calling for half a minute's silence "to collect our thoughts", and he/she then reads a "momento" directing members to think of each other, absent members, "other sufferers"(GROW, 1982,p.1) and those involved in the organisation of GROW. Another member is then asked to read the "twelve steps of personal growth"(GROW, 1983, p.5) and the whole group membership then reads together a statement of commitment, promising confidentiality in matters to be discussed at the meeting, promising not to "lead or aid a member of GROW in any serious wrong"(p.77), and making a commitment to truthfulness. Members who have attended at least three meetings are invited to make a further commitment to adopt GROW's program and principles and, finally in this segment of the meeting, members all stand, physically link hands and recite the words: "In GROW we believe in one another, we love one another, and we trust one another"(p.77).

The ritual bonding of this sequence (referred to as the "opening routine") is understood by the membership to create a safe environment in which personal and often painful matters may be discussed in an atmosphere of acceptance and trust. The "group space" described by Schlachet (1986) referring to the shared activity and understanding of therapy groups may be analogous.

This understanding is reinforced by a corresponding ritual at the end of the meeting, the "closing routine"(GROW, 1982, p.4). At the conclusion of a session of discussion of personal problems the leader calls on a member to "prepare refreshments" for a social time which will follow the closure of the meeting. This normally involves physical movement as the member perhaps leaves the room to get cups, puts on an electric kettle or whatever. During this minor disruption, the Organiser is asked to make any announcements and to make between-meeting arrangements, and all members are encouraged to respond to questions of "evaluation" of the current meeting, read from a set form, asking members whether the format of the meeting has been adhered to faithfully, and whether they consider the meeting to have been useful.

All members (including the one who has been preparing for the social time) then link hands again. They are invited to read together a "prayer for maturity"(GROW, 1983, p.79), the understanding being that those who do not believe in God or prayer observe silence but remain in the circle, and finally all recite the "GROW aspiration": "May the spirit

of friendship make us free and whole persons and gentle builders of a free and whole community"(p.79). The breaking of the circle at the conclusion of this ritual marks the end of the meeting and movement from the "safe place" the opening ritual had established.

Another feature of the structured meeting pattern merits note. The meeting is divided clearly into five segments ("routines") including the opening and closing described above (GROW, 1982). The second and fourth segments are designated for the discussion of any member's personal problems and the recommendation by the rest of the group of "practical tasks" to be undertaken, if accepted, in the week before the next meeting. The mode of these segments is essentially subjective and involves interaction between members, often emotionally charged. In contrast, an explicit attempt is made to keep the mode of the intervening segment ("the middle routine") essentially objective and the discussion of personal problems is at this stage specifically discouraged (GROW, 1982, p.3). Members ask each other questions about the content of the programme to encourage learning, and an extract from the GROW literature or another source is read and objectively discussed.

Thus there is, at the transition from the second to third segments of the meeting, a deliberate shift from subjective, self-centred interaction to objective, object-centred interaction and then from third to fourth segments the reverse shift from objective to subjective, deliberately chosen. One of the common characteristics of mental illness may be a



difficulty of adopting an attitude of objectivity; the structure of the GROW group meeting provides the opportunity for members to practice acting on a choice to be objective.

Discussing the philosophical background of cognitive psychotherapy, Perris (1988) acknowledged the influence of Kant's view that a feature of all mental disorders is the loss of "common sense" and development of a unique "private sense" of reasoning (Kant, 1964). Perris pointed out that the psychodynamically-oriented therapist, Alfred Adler had maintained that this "private sense" was one of the basic characteristics of all failures in life.

However, the point of attack for psychodynamic therapists and for behavioural and cognitive therapists has differed fundamentally, signified by the contrasting behaviour they expect of their clients (Perris, 1988).

For the patient of the classical psychoanalyst (and, in varying degree, the patients of all psychodynamic therapists) the task is to remain subjective and introspective, to report thoughts and feelings in terms of this "private sense", the therapist being responsible for interpretation. On the other hand, cognitive psychotherapy (and, in practice if not in theory, behavioural therapy) (Perris, 1988, p.36), is characterised by a collaborative relationship between therapist and client (Beck, 1976), in which "patient and therapist...work together as two research workers who formulate hypotheses, challenge their

validity and search for alternatives when they are untenable", (Perris, 1988, p.15).

Although, as Perris pointed out, the contrasting formulation and practices of psychodynamic therapists and cognitive psychotherapists have moved closer to a common standpoint in the past two decades, it is interesting to note that the lay participants in GROW, for thirty years, have acknowledged by their practice of deliberately choosing to act subjectively or objectively, a distinction which undergirds the two approaches to psychotherapy. The importance which GROW puts upon that choice is emphasised by an agenda for their weekly meeting which demands its practice by all members.

### **3.6 Mutuality and GROW's "Caring and Sharing Community"**

Beside the GROW program and its application, GROW believes a second major contributor to recovery and rehabilitation is mutuality and friendship. From almost their first association with a GROW group (GROW, 1989, p.82), members are encouraged to contribute to the leadership by being invited to lead group meetings and by actively involving themselves in group discussions. GROW thus implicitly subscribes to Reissman's (1965) theory of the helper principle: in a situation in which help is given, the helper benefits as well as the person helped (GROW, 1983, p.7, quoted above).

As mentioned above in relation to Medvene's (1985) organisational theory of mutual help groups, the organisational infrastructure of GROW reinforces this principle of mutual help, assuming some leadership participation almost from members' first contact.

Mutuality is also to be expressed as friendship, "the special key to mental health" (GROW, 1983, p.7) and the establishment of friendships and their quality is seen to be a measure of recovery and mental health. The GROW movement describes itself as a "caring and sharing community" and group membership is understood to provide a network of social support. Members are encouraged to keep in touch between meetings. Each weekly group meeting is concluded with refreshments and a time for socialising, and social functions under GROW's auspices -- barbeques, dances, socials and residential weekend camps -- are regularly arranged for the membership.

In practical terms GROW provides for its members a sense of belonging. For many, by their own report, this is the most important and perhaps the only benefit. Many reflect the words of a 35 year old female member: "Since I've been going to GROW I feel as though I've got somewhere I belong. Not like before. That gives me confidence and my family relationships are a lot better. But I rely on my GROW friends" (personal communication, August, 1989). The experience of many has been one of alienation by reason of mental illness or other personal trauma and the quality of acceptance which the first members sought from AA is provided now by GROW.

Everyone who becomes a member shares an admission that they are "inadequate or maladjusted to life" (GROW, 1983 p.5). This fosters an understanding of personal needs as being "normal" and the person with needs as being an ordinary member of the community, in contrast with the specialist tendency to understand personal difficulties as a problem and the person with difficulties as a patient or client in need of extensive and exclusive intervention (Durman, 1976).

Implicit in this aspect of the GROW movement is acknowledgement of the need for an adequate supportive network, and this will be an aspect of the movement examined in this thesis. Social support systems are widely perceived as having a crucial role in the etiology, process and resolution of mental disorders (Mueller, 1980; Henderson, Byrne & Duncan-Jones, 1981; Hammer, Makiesky-Barrow & Gutwirth, 1978) and evidence is that GROW does provide some such support (Young & Williams, 1987).

### **3.7 Relationship to Religion**

The inclusion of GROW's third "step of personal growth", "We surrendered to the healing power of God" (GROW, 1983 p.5), as a foundational part of the program, numerous references to God in GROW literature, (e.g. Keogh, 1979), and frequent references to God in the structure of the weekly meeting (GROW, 1982), have been the grounds of criticism which has suggested that GROW is better understood as a religious movement than a community mental health

movement (e.g. Wallace, 1979). The highly structured, ritualistic pattern of weekly meeting, beginning with silent recollection and formally concluding with a prayer and aspiration (GROW, 1982) lends weight to this impression.

As alluded to above, the mutual help movement has roots in religious belief and practice (Hurvitz, 1976; Oden, 1972). For GROW, the most direct link with this tradition is through the Oxford Group, an American organisation founded by a Lutheran minister, Frank Buchman, in the early 1930s. This group held, as a central belief, that people are sinners, that their lives can be changed, and that confession in a group setting and a commitment by those whose lives have been changed to change others, are necessary components of the life-changing process (Clark, 1951).

It was from this organisation that the founders of AA, Bill W. and Dr Bob, took the principles of life-changing as a spiritual process and expressed them in the "Twelve Steps" (Hurvitz, 1976), in turn the pattern of GROW's "Twelve Steps of Personal Growth" (Sprague, 1979).

While GROW argues philosophically for belief in God (and in so doing makes assumptions congruent with a Christian theology) (GROW, 1983 p.74), the programme literature is specific in stating that "no profession of religious belief....is ever required of anybody, much less imposed as a condition of membership" (p.69) and that "all positions of leadership, responsibility or authority in GROW are open to

believers and unbelievers without discrimination" (p.23). Alternatives to some parts of the programme, changing the wording to avoid references to God, are provided in an appendix to the members' handbook (pp.80-81). Nonetheless, though theological definition is avoided, the centrality of belief in God is made clear in the tenet, stated or implied, that belief is a mark of "maturity": GROW's term for mental health and the stated goal of the programme (p.2).

The view of GROW's membership on the religious dimension of the organisation and their personal affiliation will be investigated in the course of this study.

### **3.8 American Research**

Although groups had been meeting outside Australia since the late 1960s as a result of enthusiasts who had come into contact with GROW in Australia taking the idea to their homelands, it was in 1978 that the organisation was deliberately transplanted to the mainland United States by Fr Koegh and Dr Lacey with the encouragement and support of Professor O. Hobart Mowrer of the University of Illinois at Urbana-Champaign. In the belief that their success in the United States would need "scientific evidence", GROW leaders approached Professors Julian Rappaport and Edward Seidman of the Psychology Department at Urbana-Champaign with a request that they undertake an evaluation of GROW as it developed in Illinois (Rappaport et al. 1985). The subsequent extensive research, funded by a National Institute of

Mental Health grant, has produced a number of studies centering on an in vivo evaluation of the group processes and longitudinal assessment of new members of the first groups started in Illinois. Studies focus on such issues as changes in members' functioning within groups, rehospitalisation of chronically disturbed patients, and the place of the organisation in the mental health system (Rappaport et al 1985; Rappaport, Seidman & Toro 1986; Rappaport & Seidman 1987; Toro 1987; Salem, 1984, 1987; Salem, Seidman & Rappaport, 1988; Stein 1984, 1987; McFadden 1987; Zimmerman 1987; Reischl, McFadden & Zimmerman 1984; Peters & McFadden 1984; Roberts 1987; Luke 1987).

While the American research must throw significant light on the Australian organisation and its processes, the present study has some important differences. First, the American groups inherited a complete and functioning structure, including published literature. Inevitably, the transplant must have, in some measure, have been selective and Fr Keogh, Dr Lacey and the other leaders involved would be expected to have introduced the best Australian pattern. GROW in Australia may be significantly, though subtly, different from GROW in the U.S. Secondly, mutual help groups tend to change over time not only in their conduct and process but in the composition of their membership (Borman, 1979). GROW in Illinois, studied in the first years of its foundation in that context, is very different in this dimension from GROW in Australia which has been in active operation for more than 30 years. And thirdly, this study is based on the whole

national population (291 groups and 1669 individuals: Young & Williams, 1987) where the American research is based principally on the first 13 groups in Illinois (Rappaport et al, 1985).

Before the present study, reported in part elsewhere, (Young & Williams, 1987, 1988, 1989; Young, 1990a, 1990b) no research related to GROW had been undertaken in Australia. The only mention of GROW in Australia in research literature was in a brief review article (Snowden, 1980). An approach made by an academic researcher to GROW in the mid-1970s was rejected when the proposal was considered by GROW leadership to be too invasive (personal communication, A.M.Lacey, 1988). By 1985 pressure was mounting from funding authorities in a number of states for evidence that GROW's claims of effectiveness be substantiated.



## **CHAPTER 4**

### **EVALUATION OF OUTCOME**

#### 4.1 Importance of Evaluation

Social programmes should have demonstrable effects. This commonsense idea has equal appeal to potential clients of a programme, responsible providers, referral agencies, providers of funding, and theoreticians, and it is the proposition which underlies all evaluation endeavours (Berk & Rossi, 1990).

Mutual help groups, frequently spawned in response to an experienced need of the first members with little thought for organisational development, rarely anticipate a need to be explicit about effectiveness (Borman & Lieberman, 1979). However, when groups multiply with organisational coherence, appeal for support through referral or funding, or claim to meet a recognised social need, assertions about effectiveness demand evidence.

The evolution of GROW as an organisation, as has been pointed out, was part of the much wider process of deinstitutionalisation. The organisation purports to meet a demonstrable need for the continuing support and rehabilitation of people formerly living in institutional settings and has been accorded de facto recognition in this role by very considerable public funding over 25 years. Further, GROW claims a wider role as preventative and educative in the area of mental health (GROW, 1983, p.1). The membership has evolved a method and programme which, it is argued, incorporates important elements of therapeutic systems with extensive empirical backing and provides a

mode of delivery of services which appears to be economical and effective. If GROW's claims of effectiveness can be established, the implications for psychotherapy and the delivery of mental health services will be considerable.

GROW's objectives to "rebuild the lives of former mental sufferers after breakdown", to provide "prevention as well as rehabilitation" and "[to provide] a popular school of life and leadership in mental health" (GROW, 1983, p.1) are difficult to operationalise for measurement. However, if GROW's claim to provide a major contribution to the recovery and rehabilitation of its members, as well as a measure of prevention in the promotion of mental health, is to be taken seriously a study needs to be made of the short- and long-term effectiveness of its therapeutic processes. This is a more pressing need if resources which might be available for other service delivery are to be directed to the organisation. As noted above, this is the purpose of the present study.

## **4.2 Evaluation as Research**

Evaluation research, the "systematic application of social research procedures in assessing the conceptualisation and design, implementation and utility of social intervention programmes" (Rossi and Freeman, 1985, p.19), has evolved in the last two decades from commonsense programme evaluation into a mix of substantive issues and procedures of considerable sophistication and power (Berk & Rossi, 1990).

While some authorities use the terms "evaluation" and "evaluation research" interchangeable (e.g. Rossi & Freeman, 1985), Smith and Glass (1987) made a distinction in terms of the intent and purpose of the investigator: the researcher studies an intervention with the purpose of testing a theory or contributing to a general body of knowledge whereas the evaluator conducts a study to see whether a particular intervention is effective and efficient in accomplishing its defined objectives. Research is also usually motivated by the researchers' interest and curiosity and limited to theoretically defined aspects of an intervention whereas evaluation is frequently initiated by persons with a more or less direct interest in a wider socially defined programme and typically involves a series of linked interventions.

The present study adopts the paradigm of evaluation as applied research. While rigorous research standards are to be applied, the complexity of the organisation demands innovative research design. The laboratory experimental method, with random assignment to experimental and control groups would be inappropriate and ethically unacceptable. Any interference with the free association which marks GROW membership would change the essence of the organisation and the process of its meetings.

Pragmatic considerations constrained some decisions on the planned research. First, it was believed that opting for quantitative methods of evaluation rather than qualitative methods (Cook & Reichardt, 1985) would mean that the project would be more readily accepted by GROW's

funding agencies and other stakeholders. Secondly, for a similar reason and to limit the research project to manageable proportions, it was decided outcome rather than process evaluation (Berk & Rossi, 1990) would be a goal and, further, that no attempt would be made to evaluate organisational dimensions of GROW. These issues may be taken up in future research.

### **4.3 Research Design Considerations**

An organisation, membership of which is unrestricted and voluntary, with objectives defined in only very general terms, no overt theoretical background, and for which no records of participation have been kept, provides special challenges when attempting an outcome evaluation.

Problems associated with outcome studies of mutual help groups generally have been noted by Gottlieb (1985) and these add to a number of such factors peculiar to GROW which had to be considered in designing an appropriate research plan.

First, membership of GROW is open to all and there was no record kept of membership numbers, names, or regularity of attendance at meetings. Further, these are guarded as important characteristics: voluntary and uncoerced attendance is understood as a sign of willingness to undertake the programme, and anonymity and confidentiality are guaranteed. Any attempt to manipulate attendance

at GROW meetings, (supposing it could be done ethically), would, by definition, violate the integrity of the organisation.

Secondly, GROW takes pride in the fact that it is not a professional organisation and leaders had made it clear that they would resist what could be seen as professional intrusion. A degree of participation in GROW by the researcher and use of results of research in a formative sense were understood to be one of the prices that would have to be paid for co-operation.

Thirdly, the administration of the organisation, largely of a voluntary nature, could not reasonably be expected to undertake accurate and reliable collection of data so that sufficient resources would have to be made available for non-intrusive data gathering by the researcher himself or his confederates.

Finally, the organisation would not tolerate any interventions which members might see as interfering in any measure with its primary objective of meeting its members' emotional, psychological or spiritual needs.

Given the artificiality of anything but currently established GROW groups it was decided that a quasi-experimental design would be appropriate (Hormuth, Fitzgerald & Cook, 1985). A quasi-experiment is a study designed to establish a cause-and-effect relationship between independent and dependent variables when the assignment of subjects

to treatment groups is not random (Cook & Campbell, 1979). If repeated measures of appropriate variables could be devised, to be compared internally among groupings of GROW members demonstrably different in their pattern of participation, changes over time, if any, might be attributable to differences in participation in GROW. Conclusions from such research might be strengthened by recruitment of a non-equivalent comparison group, matched as closely as possible with GROW members on variables other than contact with GROW, and subjected to the same measurement regime (Smith & Glass, 1987).

After extensive negotiations with GROW's national and state organisations it was agreed, that provided (1) confidentiality and anonymity could be guaranteed; (2) participation of individuals would be voluntary and uncoerced; and, (3) relevant levels of the organisation would be constantly consulted and informed; the projected research might be undertaken.

It was decided that questions relating to the organisational structure of GROW or cost-effectiveness would not be addressed, and the study would be confined to the level of group and individual GROW member.

The collaboration implied in the conditions agreed to was made easier by the author's earlier involvement with GROW as a state programme co-ordinator for four years (1980-84). The fact that the relationship with the organisation was established long before the

present investigation was commenced might be expected to minimize reactive effects (D'Aunno, Klein & Susskind, 1985, p.459) but the dilemma that such a relationship provides was recognised. "The potential for investigator effects is maximized in the study of self-help groups, but realistic collaborative arrangements are required to gain access and maintain active involvement with them", Lieberman and Borman observed (1979, p.6). An endeavour was made to maintain an appropriate balance between minimizing reactive effects and responding to individuals in distress; possible investigator effects will be considered in discussing results.

Before any assessment of outcome could be undertaken, it was necessary to undertake a descriptive study of the organisation to determine the characteristics of the membership and group processes. It was expected that it would thus be possible to estimate external validity of subsequent studies of a sample population and to determine the necessary dimensions of such a sample. Borrowing something of the grounded theory method of data analysis (Glaser & Strauss, 1967), it was also anticipated that data from such description would provide information enough to formulate hypotheses for an effectiveness study.

#### **4.4 Three Phase Study**

The study was planned in three phases, the first two to be essentially descriptive of the organisation, its processes and its membership, the third an assessment of outcome and effectiveness.



Phase 1 would be a cross-sectional survey of the Australian membership seeking information in six areas: demographic details; social network; religious affiliation; involvement with GROW and perceived help; reason for becoming a member; and, help sought and/or received from other sources for the same problems and the relation of such help to that received from GROW. The objective would be to provide a basic profile of the organisation and its members, and to provide some guidance in the design of proposed further stages of research and evaluation.

Data from a national cross-sectional study might also allow the development of a typology of membership. It has been a consistent challenge in psychotherapy to identify particular therapeutic interventions as appropriate for particular people in differing settings (Urban & Ford 1971). Thus it is appropriate not only to identify the processes involved in GROW's operation but the characteristics of the population to which they are applied.

The history of the development of the organisation, originally composed of members all of whom had been hospitalised for serious mental illness and later expanding to admit others who had never had any treatment or diagnosis of mental illness, (Keogh & Lacey, 1979), suggests a heterogeneous population. This allows the speculation that there may be definable groups of GROW members whose objectives may differ and even be antagonistic. Large group comparative research

designs with vague subject parameters may lose changes by averaging them across subjects (Barlow & Hensen, 1984). It was considered worthwhile, therefore, to analyse data from the initial survey of GROW membership to determine whether recognisable and meaningful subtypes could be identified.

Phase 2 would involve first a measure of the group processes and social climate of GROW groups. If the ideology of GROW is a dominant determinant of groups' process, (Levine & Perkins 1987; Levine, 1988; Antze, 1976, 1979; Suler, 1984) it is argued that the social climate of the groups will reflect that ideology. For example, an authoritarian, task-oriented group climate would reflect an ideology which promoted external control and the acceptance of received conditions; a cohesive group climate, encouraging self-expression would reflect an ideology endorsing egalitarianism and solidarity but also the heuristic value of individual experience.

Attitudes toward leadership -- an aspect of the social climate of the group -- might also give some insight into the importance of leadership participation and help-giving by the membership which Gartner and Reissman (1982; Reissman, 1965) proposed as one of the key principles in mutual help groups.

Some theories reviewed above suggested specific behavioural and cognitive processes which might determine mutual help groups' effectiveness (Levy, 1979; Kilillea, 1976). An attempt would be made in Phase 2 to identify, in terms of established cognitive and behavioural procedures, what processes, if any, were used in GROW groups.

The significance of supportive relationships and interaction within that context was emphasised by some theories (Borkman, 1976, 1984; van der Avort, 1985; Levine, 1988). Phase 2 would attempt to gauge the extent of support available to members of GROW both within the organisation and outside it and also attempt to measure some of the qualities of support which members perceived. Consideration of these qualities, together with some understanding of the processes within GROW groups might allow reflection on interactional dimensions central to the theories of Borkman and van der Avort.

One of the prime concerns of federal and state governments and other funding agencies related to the specific population of former patients (and, perhaps, prospective patients) of psychiatric facilities. Were GROW members consumers or potential consumers of other public resources? If GROW provided some benefits to its members, was this an addition or alternative to other benefits?

Phase 2 would attempt to point to an answer to the first of these questions by measuring psychiatric symptoms of GROW members in a way which would allow comparison with other populations and would follow up questions of the use of other resources which had been part of Phase 1.

One of the anticipated limitations of the national survey of Phase 1 in describing the extent of the organisation was its cross-sectional nature. As already noted, GROW deliberately avoided keeping records of members' attendance in the interests of confidentiality and anonymity.

Yet if there was to be any accurate estimate of the number of people reached by GROW, a record over time, or at least a careful estimate of patterns of members' attendance at meetings, would be necessary. Subject to negotiation with the organisation, it was proposed to undertake recording of attendance at a representative sample of groups in conjunction with Phase 2 of the investigation.

In summary, a battery of questionnaires, with established psychometric properties, to measure psychiatric symptoms, group processes, social environment and perceived social support would be administered in a sample of groups selected on the basis of the Phase 1 results to conform to GROW's national profile. At the same time data would be collected on attendance patterns at group meetings and subjects' use of other resources and medication.

The emphasis of Phase 3 of the study would be on outcome. Practical considerations of time and resources would limit a quasi-experimental longitudinal study to about 100 GROW members. They would again be selected on the basis of Phase 1 results to conform to members' Australia-wide profile in terms of demographic characteristics and group membership. Four measures would be taken at two-month intervals with one follow-up interview at least six months later.

Changes over time in any psychiatric symptoms subjects might display, would provide evidence, if the changes were positive, that

GROW members would be becoming less likely to be consumers of other mental health resources. As already mentioned, this dimension was a primary concern for funding agencies with a stake in GROW's operation and, consequently a concern for GROW leaders. A measure of psychiatric symptomatology similar to that used in Phase 2, would provide data on such changes if any. Data could also be obtained, over the year of the study phase, of members' concurrent use of medication or professional help.

A second relevant measure would endeavour to detect changes in subjects' social network. The link between social support and mental health (Mueller, 1980; Henderson, Byrne & Duncan-Jones, 1981; Hammer, Makiesky-Barrow & Gutwirth, 1978) has already been mentioned. It has also been noted that social network is a consideration of significance in theories of the operation of mutual help groups (Borkman, 1976, 1984; van der Avort, 1985; Levine, 1988). The detail of the measure to be used would depend in part upon the results of Phase 2 but an effort would be made to determine changes during the year of the Phase 3 study in both size of social network and its quality in terms of subjects' satisfaction.

A third measure of change would link a cluster of measures related to a broad definition of "quality of life". Acknowledging Fava and Magnani's observation in a recent review (1988) that there was no accepted definition of quality of life and that "Quality of life...eludes measurements and classifications" (p.1051), the concept has

nonetheless been used increasingly in the assessment of the effectiveness of a wide range of health programmes (Fava & Magnani, 1988). Discussing problems of measuring outcomes in mutual help groups, Lieberman and Bond (1978) suggested relevant outcomes are addressed by assessment of quality of life measures because they tap both psychological adjustment and social role performance. Baker and Intagliata (1982) argued convincingly for the use of a measure of quality of life in evaluating outcome of a programme for chronically psychiatrically ill people. In spite of a number of problems use of the concept of quality of life entails, they maintained that such a measure takes account of the fact that "comfort rather than cure" (p.69) may be a realistic objective; that the complexity of outcome justifies the use of a multi-dimensional variable; that the satisfaction of a target population is a legitimate goal; that the quality of life concept is consistent with a wholistic view of health; and that "[quality of life] is good politics" (p.70).

The study cited and others (e.g. Lehman, Ward & Linn, 1982; Lehman, 1983; Lehman, Possidente & Hawker, 1986; Anstey, Burgess & Brebner, 1987; Cheng, 1988) have shown the use of the quality of life concept to be a useful way of evaluating conditions of the chronically mentally ill in the community. However, Lehman et al. (1982) pointed out the unsolved problem of translating the concept of quality of life into measurable terms, (p.1271), and Cheng has warned that "one needs a 'whopper' effect to appropriately use a [subjective quality of life] measure in program evaluation" (1988, p.131). Andrews and Withey

asserted that "the notion of measuring the quality of life could include the measurement of practically anything of interest to anybody. And, no doubt, everybody could find arguments supporting the selection of whatever set of indicators happened to be his choice" (1976, p.6).

For the purpose of this study it was decided to confine measurement to perceptions of well-being for three reasons. First, as Andrews and Withey observed, "the promotion of individual well-being is a central goal of virtually all modern societies and of many units within them" (1976, p.7) so that reported improvements in members' perception of their own well-being could be expected to be widely recognised as a beneficial effect. Secondly, supposing it was possible adequately to define criteria to measure "objective" quality of life (Andrews & Withey, 1976, p.5) these would not have direct relevance to the stated objectives of GROW (GROW 1983, p.1). Thirdly, it was considered that changes in perceptions of well-being would be more likely to be significant over the limited period of a longitudinal study than changes in objective indicators.

Data would also be sought on subjects' use of other resources and medication and their attendance at GROW meetings during the course of the study.

At the same time, it was considered, a standard checklist of life events (Heady et al, 1985) should be administered as a check variable to see whether changes in measured variables, if any, were systematically related to some of the more obvious life events.

A nonequivalent control group matching members of the subject group in demographic terms and as far as possible on other variables would be recruited from people who had had no contact with GROW, to be given four similar interviews at two-month intervals. The recruitment and maintenance of such an appropriate group, it was recognised, would provide substantial logistic problems. Resources did not allow access to objective criteria for matching such as medical or public agency records and, in any event, GROW members did not appear to fit any such accessible category. It was decided, therefore, to recruit a nonequivalent control sample from people who contacted a number of agencies in Melbourne, centred round an agency set up to promote adult literacy, and to attempt to match individuals of the GROW sample with individuals of the control sample.

A more detailed description of measures used in each of the three phases of the investigation is given in following chapters.



## **CHAPTER 5**

### **PHASE 1: A NATIONAL SURVEY**

## 5.1 Method

A thirty-item questionnaire was developed by the author in consultation with GROW leaders and members and subjected to pilot trials in Tasmania. The questionnaire sought information in six areas: demographic details, (so that the GROW population could be set in context); social network, (which is widely held to be directly related to mental health [e.g. Cohen and Wills 1985; Henderson, Byrne and Duncan-Jones, 1981] and may be a critical factor in the extent of GROW's effectiveness); religious affiliation and practices, (since it had been suggested that GROW was essentially a belief system and that specific religious orientation was a hallmark of members); GROW involvement and satisfaction (to get some indication of how central membership of GROW is in the lives of its members and how it met perceived needs); reason for becoming a member, (to see whether the needs which members perceived fell into definable or recognisable categories); and, help sought and/or received from other sources for the same problems that brought people to GROW and the relation of such help to that which might be received from GROW, (to see whether GROW membership is related to demands on other resources). A copy of the questionnaire is appended (Appendix A).

Most of the information was sought by closed question. Checklists were developed with GROW members for the reasons for attending GROW and help received, and visual analogue scales with five anchor points were used for rating members' opinions. Language familiar to GROW members was used in framing questions.

The questionnaire was then taken to each state in Australia by the author and introduced to GROW members at regional and state meetings. Some isolated groups and group organisers who did not attend the regional or state meetings were visited individually by the author and the few groups which could not be visited in person were contacted, through the organisers, by telephone. The group organisers were given plastic coated "Research Participant" cards (Appendix A) enough for the maximum size of their respective groups. The cards, each bearing a five-digit number, were to be given to all group members in attendance at one meeting whether or not they agreed to fill out a questionnaire. If a regular group member happened to be absent from the meeting, they could be given a participant card and a questionnaire to be included in the group's response. Group organisers were encouraged to have as many members as would agree to do so complete the questionnaire at the group meeting but the actual administration to individual members was left in the hands of the organisers who then returned the completed questionnaires together with any unused research participant cards by mail.

To back up the personal approach, organisers were given a letter repeating the instructions (Appendix A).

## 5.2 Results

### 5.2.1 Response Rate

Of 313 GROW groups reported to be meeting throughout Australia in the last quarter of 1985, 291 (93%) returned questionnaires; of the 1864 persons attending responding groups, 1669 (90%) returned completed questionnaires. Table 1 shows state by state response rates.

**Table 1: Response rates with Phase 1 questionnaire, percentages of total in parentheses.**

State	Groups (%)	Individuals (%)
New South Wales	78 (94)	450 (84)
Victoria	66 (93)	417 (91)
South Australia	50 (100)	241 (94)
Queensland	42 (89)	274 (91)
Western Australia	39 (87)	221 (93)
Tasmania	11 (92)	52 (95)
Northern Territory	5 (100)	14 (78)

A comparison was made among results from all states on all variables and, tested by Yates' corrected chi-square, with criteria of  $p < .05$ , no significant differences were detected. In other words, on the variables measured, GROW appears to be uniform across Australia.

### **5.2.2 Demographic Factors**

Of the 1669 respondents, 66% were females; 40% were aged 31-45, 25% aged 45-60, with 18% under 30 and 11% over 60; 45% were married, with 26% single and 22% separated or divorced; 45% had left school at 15 or younger with 25% going beyond high school; 58% lived with their partner and/or children and 20% on their own (missing values account for unreported percentages). In a five-point employment status scale (high=1) (Daniel 1983), 29% were on each of the third and fourth ranks, with 6% above and 19% below those levels; (17% of responders had missing values on this dimension).

### **5.2.3 Social Network**

Thirty-three percent had fewer than five friends other than other GROW members or immediate family but 68% reported having contact with other GROW members, other than at the regular meetings, at least once a week. Eighty-eight percent had at least one person with whom they were able to share almost anything, and for 58% of the total such a person was a fellow member of GROW.

Social support and social network will be the subject of further investigation at phase 2 and phase 3 of this investigation.

#### **5.2.4 Religious Affiliation and Practice**

Thirty-seven percent claimed no religious affiliation, 26% were Roman Catholics, 31% belonged to some other Christian body, and 2% professed some other religion. Forty percent of all GROW members attended a religious observance at least once a week and a further 29% attended at least once a month. Asked how religious-minded they considered themselves to be, 49% thought they were about average, with 33% rating themselves as more religious-minded than average, and 16% less than average.

#### **5.2.5 GROW Involvement and Satisfaction**

One third of all GROW members had been a member for two years or more, 10% for one to two years, 47% for less than a year and 9% for less than a month. Most had heard of GROW from a friend (34%) and 25% had been referred by a helping professional. On a five-point scale, 93% rated GROW as either "very helpful" or "extremely helpful" with the problem which brought them to GROW, and 78% said that GROW had exceeded their expectations.

The following percentages (N=1669) checked specific forms of help received from GROW:

Saw others' view	74%
Controlled feelings	72%

Gave sense of belonging	72%
Taught help for others	67%
Changed behaviour	66%
Felt less lonely	65%
Felt less fearful	54%
Provided activity	44%
Other help	16%
Gave no help	1%

### **5.2.6 Reason for Joining GROW**

Members checked reasons for first attending GROW in the following percentages (n=1669):

Misery/depression	66%
Anxiety/nervousness	64%
Loneliness/isolation	55%
Family problems	43%
Uncontrolled feelings	42%
Fears of places/people	31%
Unhappy relationship	31%
Guilt	31%
Recovery after hospital	25%
Physical illness	19%
Broken relationship	18%
Unemployment/finance problems	14%

Drinking or drug problem	12%
Bereavement	11%
Other	9%
Low self esteem	4%
To help others	4%

### **5.2.7 Help from other sources**

Eighty percent of GROW members reported having sought professional help for the problems which brought them to GROW and 40% had sought help from sources other than professionals. Medication to help with their problems had been taken at some time by 79%. Fifty-seven percent rated the help they received from other sources as helpful while 43% said it made no difference or made matters worse.

## **5.3 Discussion**

### **5.3.1 Demographic factors**

Although categories are not closely enough aligned to allow anything but the broadest comparisons, there are apparently some notable differences between the proportion of GROW attenders and the Australian population as disclosed in census figures (Cameron, 1983). Comparisons which could be made are shown in Table 2.



**Table 2: A comparison of GROW demographic characteristics with Australian census figures.**

	GROWm'ship%	Aust. pop'n%
<b>Sex</b>		
Male	33.0	49.8
Female	67.0	50.2
<b>Age</b>		
< 20	2.0	36.0
21-30	16.0	16.0
31-45	40.0	18.0
46-60	25.0	16.0
> 60	11.0	13.0
<b>Marital Status</b>		
Married	45.0	60.0*
Single	26.0	27.0*
Sep/div	22.0	6.0*
Widow	6.0	7.0*
<b>Education</b>		
Left school <15	45.0	49.0
Finished high school	26.0	
Some tertiary	11.0	
Qualif. tertiary	14.0	24.0**
<b>Work Status</b>		
Employed	37.0	61.0*

\*Population > 15 years

\*\*Some post high school qualification

Major differences of note between GROW population and the Australian population relate to the imbalance of the sexes with about two-thirds women in GROW; the low proportion of married people

(about three-quarters of the Australian proportion) and high proportion of the separated and divorced -- nearly three times as many as predicted; and the high proportion of unemployed. Though almost twice the proportion of GROW members are 31 to 60 compared with Australia's population, if under 20s are excluded the proportions are much closer - 66% in GROW compared with 53% in the whole population.

### **5.3.2 Religious Affiliation and Practice**

Reported religious affiliation differs markedly from Australian census reports. For the Australian population 11% report no religion, compared with 37% of GROW members reporting no religious affiliation (Cameron, 1983). The percentage of Roman Catholics is similar for both GROW and the Australian population (26%), but the GROW percentage of 31% of non-Roman Catholic Christians compares with 50% of the Australian population. Numbers of affiliates of other religions, (GROW, 2%; Australian census, 1.4%), do not differ notably in the two populations.

There are some obvious inconsistencies with the proportion of GROW members claiming no religious affiliation. Three times as many members as would be predicted from census figures make this report. While there are other notable differences between the Australian population and GROW membership (e.g. a 66% female GROW membership compared with 50.2% of the Australian population), and

no direct comparisons can be made, the difference in professed belief is unexpectedly wide. Inconsistent with this is the report of 69% of GROW members that they attend a religious observation at least once a month, and, paralleling this inconsistency, 82% rate themselves as at least as religious-minded, or more so, than most people.

A possible explanation of this is that some members may see GROW as a secular religion, allowing an unaffiliated ascription to a higher power. This would align with theories (Antze, 1979; Suler, 1984; Levine, 1988) which emphasise the ideological role of mutual help groups, and the prediction of Mowrer (1971) who saw small peer groups as "the emerging 'church' of the 21st century.

Oden (1972), discussing processes in intensive small groups, perceives elements of a "demythologized, secularized Judeo-Christian theology"(p.89). He suggests that dealing with a person who experiences guilt and anxiety, a group makes: "an implicit assumption of the trustworthiness of reality itself which is in fact made explicit in the Christian kerygma which announces that God has taken the initiative in addressing history with his infinite forgiving love and making himself known as trustworthy. So in a sense the group performs a representative ministry, trying to get through to persons in the group that they can trust others because here and now reality is trustable and that they need not be radically guilty, that they can be open with others, that they can accept themselves since they are in fact accepted. Accepted by what? Not finally by the group itself but by some principle intrinsic to creation itself." (p.94).

Though Oden was commenting particularly on the encounter group movement, he broadened his definition to include groups existing "at a level of emotive depth in personal transactions"(p.23), and traced the heritage of encounter groups from Wesleyan pietism, also related in a direct line through the Oxford Group (Clark, 1951), to GROW groups (Hurvitz, 1976; Sprague, 1979).

From a psychological aspect, Thouless (1971) notes the psychotherapeutic value of confession: a practice systematized in varying degrees in Christian bodies and many other religions and sometimes formalised in self-disclosure in small groups. In GROW the injunction to "tell the untellable" (GROW 1983, p.52) is an important feature within the safe space of the group meetings set aside for the discussion of personal problems. Many members testify to the release they experience with this process: e.g. "The group didn't pull me apart and were not shocked with what I had said.... Then someone said something that clicked: 'You should resume quickly and without fuss'. My treatment tapered off and I was discharged from hospital after five years." (Sprague 1979, p.43).

### **5.3.3 Membership and Professional Help**

A comparison was made between the length of time members had been in GROW and their use of other help. Among those who had at some time taken medication for the problem that brought them to GROW or who had sought professional help for that problem the

decrease in numbers still taking medication or seeking professional help approached significance (Medication: Pearson's  $r = .04680$ ,  $p = <.04$ ; Professional help: Pearson's  $r = .07331$ ,  $p = <.004$ ). The decrease in help sought outside GROW is apparent in Table 3.

**Table 3: Decrease of use of professional help and medication.**

Decrease in help (%)	Time In GROW				
	<1 mth	<3 mths	3mths-1yr	1-2 yrs	>2 yrs
Medication	24.5	27.6	30.6	35.7	35.9
Prof'l Help	22.5	32.6	33.3	38.8	43.8

In this respect GROW appears to be similar to Recovery Inc., a mutual-help organisation in the United States. N.Raiff (1984) reported 39.1% improvement in reduction of professional help sought and 49.1% reduction in medication taken among members of that organisation.

It is noted that the closed questions ("Have you ever had prescribed medication...." "Do you take any such medication now?") may disguise a decreased use of medication. During the interviews in Phase 3 of this investigation, members often remarked on their decreased reliance on medication: e.g. "I find I can cut down on the valium if I follow the [GROW] programme. When I missed a few meetings, I found I had to take more valium to stop the panic" (45 year old male GROW member, personal communication, November, 1988). By the same token the

questions used (and the corresponding questions relating to professional help) do not allow the conclusion that decreased use of these resources necessarily followed the start of attendance at GROW, though the linear relationship between the decrease and time in GROW increase the probability of such a conclusion.

The use of professional resources and medication is further investigated at succeeding phases of this study.

#### 5.4 Typology of Membership

The reasons given for first attending GROW were subjected to factor analysis using SPSS-x factor algorithm (SPSS, 1986), and five factors were identified. If a factor loading of  $>.48$  was taken as a cut-off point in the rotated factor matrix, all the data were accounted for in the five factors (Table 4).

**Table 4: Factor analysis of reasons for first attending GROW (loadings).**

Factor 1	Factor 2	Factor 3
Anxiety/nerv'ness (.740)	Unhappy relat'ps (.731)	Recover after hosp(.586)
Misery/depression (.677)	Broken relat'ps (.649)	Lonely/isolated (.557)
Uncont'd feelings (.643)	Family problems (.626)	Drug, alc'l probs (.514)
Guilt (.548)		Unemployment, finance problems (.487)
		Fears (.481)

Factor 4	Factor 5
Bereavement (.596)	For someone else (.514)
Physical illness (.622)	

On the basis of this analysis five initial cluster centres were specified for a Quick Cluster algorithm, an SPSSx data analysis option which assigns cases to the centres which are nearest, (SPSS Inc.1986). The five clusters which were produced provided the data for a Problem Index which expresses the ratio of the proportion of reports of a particular problem (expressed as a percentage) in a cluster to the proportion of subjects in that cluster. Thus a homogeneous division of subjects into five clusters produce an Index of 1.00 for each problem: divergence, positive or negative, from 1.00 by a specific Problem Index indicates disproportionate representation of that problem within the cluster. Levels of the Problem Index identified the clusters. (Table 5).

From the check list of 15 presenting problems, a problem density was also calculated; i.e. the average number of presenting problems reported by each subject in a cluster. For the whole sample the mean was 4.80, SD 2.44.

**Table 5: Problem Index - Ratio of reports of problems to proportion of subjects by cluster.**

Reasons for joining GROW	Cluster 1 n=467	Cluster 2 n=276	Cluster 3 n=115	Cluster 4 n=87	Cluster 5 n=332
Guilt	1.63	.38	1.00	.15	.09
Uncontrolled feelings	1.60	.47	1.07	.07	.07
Anxiety/nervousness	1.41	.65	1.10	.61	.29
Misery/depression	1.38	.91	.97	.40	.25
Broken relationships	.78	2.53	1.51	.31	.30
Bad relationships	1.00	2.31	.94	.19	.13
Low self esteem	1.05	1.94	.71	.00	.91
Family problems	1.02	1.80	.62	.44	.22
Finance/employment probs	.98	.75	4.48	.50	.17
Drugs/addictions	.92	.73	4.20	.36	.46
Recovery after hospital	1.03	.62	2.90	.63	.66
Fear of places/people	1.28	.57	2.77	.40	.19
Bereavement	1.01	.48	1.77	5.11	.00
Physical illness	1.15	.56	1.91	3.55	.03
For someone else	.20	.21	.00	.65	4.19
Other reasons	.87	.79	1.59	1.00	1.31
Loneliness	1.11	1.11	1.74	.81	.39

Some variables other than the problems with which these members joined GROW, also distinguish the clusters from the total sample and significant differences ( $p = <.05$ ;  $p <.01$  for all but differences marked with an asterisk) as measured by chi-square are reported below. Two adjustments made comparison among clusters clearer: as there were few representatives of the top ranks of the occupational status scale, the



scale was collapsed from five to three points, and as Cluster 5 deviated markedly from the total sample, this cluster was excluded in calculating significant deviation of the other clusters. (A table of significant chi-square values is included in Appendix A).

#### **5.4.1 Cluster 1**

Cluster 1 includes just over half the total sample ( $n = 867$ ). The problems which were reasons for first going to GROW members identified as guilt, uncontrolled feelings, anxiety or nervousness, and misery or depression. Fear of strange places or people was also a problem more frequently represented than expected. The problem density for this group was not significantly different from that for the whole sample though higher than average.

This cluster is also characterised by a higher proportion of females and married or widowed persons. Fewer have an educational level beyond high school. Significantly more report help from GROW in learning to control their feelings.\*

#### **5.4.2 Cluster 2**

Cluster 2 has a high representation of those problems which may be identified as "network" problems: broken relationships, bad relationships, and family problems. Also disproportionately represented in this group is low self esteem though the total number of

people reporting this problem was small (4% of the total sample). Loneliness or isolation, which had been postulated as a "network" problem, is not notably over-represented in this cluster but is close to an expected level or higher in all clusters except Cluster 5, suggesting a common feature of most GROW members. The problem density for Cluster 2 is almost exactly on the expected mean. Significantly more than in the total sample are over 30, and more are single or separated than married or widowed. More than expected have no dependents.\* Compared with the whole sample, more report GROW as being on the extremely helpful end of a five-point scale\* and say that GROW has exceeded their expectations\*, but fewer report the help they receive as either "giving them something to do" or "making them less fearful". Although the number who have ever sought professional help is not significantly smaller, fewer have ever taken medication for the problem that brought them to GROW. However, of those that have taken medication and have seen professionals for their problems, significantly fewer now do.

#### 5.4.3 Clusters 3 and 4

Clusters 3 and 4 may be best understood as characterised by high frequency of problems relating to adverse life events. In Cluster 3 these are unemployment and financial problems, alcohol or other drug addiction or dependence, and hospitalisation, while in Cluster 4 they are bereavement and physical illness. Fear of strange places or people, a problem disproportionately represented in Cluster 3, would not appear

to belong to the same class of adverse life events as the other dominant problems, but may be a consequence of such events. Besides the dominance of bereavement and physical illness in Cluster 4 and the comparative unimportance of other adverse life events, a distinguishing feature between the two clusters is the problem density; for Cluster 3 the index is 7.81, more than one standard deviation above the average for all clusters (4.80), while in Cluster 4 the density index is 3.21. In other words, members of Cluster 3 identify many more problems than do members of Cluster 4.

#### 5.4.4 Cluster 3

Other factors distinguish Cluster 3 from Cluster 4. Cluster 3 is characterised by having more males and more single people, under 30 years of age, who live with their parents or siblings, than the whole sample. More of Cluster 3 than of any of the other clusters report having fewer than five friends\* and that GROW helped them by making them less lonely. However, negatively, more of this cluster report that for them GROW made no difference or even made things worse\* but it did "give them something to do". Compared with other clusters, more of Cluster 3 were referred to GROW by professionals, more are seeing professionals now and have sought help from non-professional sources\* other than GROW. Though not significantly more have ever taken medication to help them with the problems that brought them to GROW, of those that have, more are still taking medication. Significantly more of this cluster are on the lowest rank of a three point occupational status scale.

#### 5.4.5 Cluster 4

On the other hand, more of Cluster 4 are over 60, widowed and live on their own. More than other clusters, they have some religious affiliation.\* Participation in GROW has changed their view of their problems only moderately or not at all.\* Compared with the total sample, fewer report GROW's help in changing their behaviour, being less fearful or controlling their feelings. Fewer have ever used medication\* to help them with the problems that brought them to GROW, but of those who have, a higher proportion still do.\*

#### 5.4.6 Cluster 5

Cluster 5 is distinguished by members reporting far fewer problems than members of any other cluster and the problem density mean of 1.43 is significantly lower than other groups ( $t=3.092$  on a two-tailed test;  $p<.05$ ). Far fewer in this cluster than in any other cluster report loneliness as a problem. Another notable characteristic is that almost all (87%) of those reporting first going to GROW not for themselves but for the benefit of others, are included in this cluster.

Compared with the whole sample, more of Cluster 5 are males, have no children\* (though not significantly fewer dependants) and have had some tertiary education or are graduates. More come from the highest rank of a three point occupational status scale\*, and more rate themselves as more religious-minded than most people. Although the

number who know someone with whom they could share almost anything is not significantly different from other clusters, fewer know any such person in GROW. More have been attending GROW for less than a year\* and the proportion of these have been at GROW for less than a month is also significantly higher than the other clusters.

Asked what benefit they had received from membership in GROW, Cluster 5 members, compared with members of other clusters, more frequently reported no help in feeling less lonely, making behavioural changes, being given something to do, changing their view of their own problems, controlling their feelings, feeling less fearful, showing them they could help others or gaining a sense of belonging. This matches the observation that this cluster acknowledged significantly fewer problems than other clusters when coming to GROW. For a significantly larger number of this cluster GROW no more than met their expectations or did not meet their expectations. Cluster 5 is also characterised by fewer members who have sought help from professionals or non-professional\* sources other than GROW, or have taken medication for the problems which brought them to GROW.

In summary, GROW in Australia consists of five clusters which, though in concept they have a degree of overlap and duplication, may be characterised thus:

Cluster 1: Middle aged, married/widowed group, toward the low end of the occupational spectrum, more than 2/3 of them women who have

problems of affect and who are helped by GROW to control their feelings -- a "symptom" group.

It is noted that problems which define Cluster 1 are similar to problems which originally inspired the formation of the Recovery group of newly-discharged mental hospital patients (later to become GROW) in 1957.

Cluster 2: Older, single/separated, also about 2/3 women, with no dependants and many relational problems who find GROW meets their needs by enhancing their social network and find now that they can decrease their medication -- a "network" group.

Cluster 3: Younger, more of them males, still lower on the occupational scale, who have experienced some adverse life event: unemployment, financial problems, addiction. They report a wide range and high frequency of problems which GROW does little to alleviate other than giving them something to do -- a "trauma" group.

Cluster 4: Older, widows/widowed, who report little change in their conditions. They have some characteristics of Clusters 3 and 2; a group who have experienced adverse life events such as bereavement or physical illness a result of which has been to diminish their social network -- a "bereaved" group.

Cluster 5: More males, middle aged, who have no children, higher occupational status and better educated. They disclose few problems and report little help from being in GROW and have not been in GROW for as long as members of other clusters. The cluster includes almost all those who expressed an aim to help others -- a "helper" group.

Two points need to be considered while interpreting these results. First, there is no indication of how long members of GROW remain members and the results may be weighted by a large number of "transient" members. The fact that 20% of members had been in GROW for less than three months suggests this possibility. This caution may be related particularly to Cluster 5, with the number of members reporting short time membership significantly greater than other clusters. A study of the pattern of attendance, planned in conjunction with Phase 2, should make this clearer.

Secondly, the data, obtained by self report, provides a description of members' perceptions: as important as, but not necessarily coinciding at every point with, an objective description. Any distortion which reliance on self report for data may engender is unlikely to be uniform across all subjects. More disturbed subjects are likely to have less insight into their own condition and to return a more distorted report of their reasons for attending GROW than those who are less disturbed. The typology, based on this data, may thus contain inherent inaccuracies. A related point is made by Levy in an unpublished paper quoted by Jacobs and Goodman, (1989, p.539). On the other hand, the large sample on which the typology is based may mitigate this effect.

#### **5.4.7 Palliative and Facilitative Support**

It would appear that the interests of the disparate groups postulated in the typology may at some points be antagonistic. For example, the interest of members of the "network" cluster and the "bereaved" cluster might best be met by maintaining a group of stable membership in the long term, whereas the interests of members of the "symptom" cluster may best be met by gaining necessary skills and strategies to obtain a cure or symptom reduction and moving beyond the group.

There appears to be abundant evidence of the inter-relationship of size and nature of social network and psychological well-being, (Gottlieb, 1981). Conversely, people suffering varying types of psychopathology have been shown to have impoverished or dysfunctional social networks, (Tolsdorf, 1976; Silberfield, 1978). However, Pattison and Hurd (1984), point out that social networks are not necessarily supportive but may involve interactions which range from beneficial to noxious.

Similarly, there is strong empirical support for the belief that social support systems provide a stress-buffering role, (Cohen and Wills, 1985), but the manifestation of support, to be beneficial, may have to differ according to the type of adverse events which occasion stress. Weiss, (1976), found that people in crises (corresponding to the "trauma" group) seem to be able to use no form of help other than the presence and availability of others. A second category, people in the



stress of transition states, (the "symptom" group), can profit from guidance, advice and access to an accepting community in addition to support, while a third category, people in stressful deficit situations (the "network" group) seem to require a continuing, problem-focused support system.

In so far that GROW has the opportunity to fulfill the purpose of its founders, (that is the rehabilitation and integration into the community of those who have been seriously mentally ill), it would seem important that social support that it provides to its membership be facilitative, facilitating personal change, rather than palliative, maintaining unchanging comfort. With GROW's changes in population, that may have changed. This may not be a problem unique to GROW but that any mutual-help group founded to provide social support for change within its members' lives may, perhaps by reason of changing population or changing programme emphasis, inadvertently change the nature of the support it offers so that it is palliative rather than facilitative.

Granovetter, (1973), writing of the comparative strength of interpersonal ties, makes a parallel distinction. Weak ties may be indispensable to individuals' opportunities and to their integration into communities, whereas strong ties, breeding local cohesion, may paradoxically lead to overall fragmentation.

It is clear that the GROW population is diverse: no doubt some of its members are better served by its processes than others but where the

balance lies and how the rehabilitative and supportive roles are meshed demands a more detailed examination of the groups' processes and the climate the groups maintain. Phase 2 of this project will attempt to elucidate this.

## 5.5 Summary

In summary, phase 1 of this investigation depicts GROW as an organisation, about two thirds of whose members are female and two thirds between the ages of 30 and 60, with more than 90% of members in the lower half of an employment status scale. Almost twice as many as would be predicted from census figures are unemployed, and nearly three times as many divorced or separated. Though a larger than expected proportion of the members do not profess any religious affiliation, many consider themselves more religious-minded than most people. This underscores the importance of GROW's ideological perspective which is vigorously stated in much of the organisation's literature.

Some GROW members reported having sought professional help or taken medication for the problems which brought them to GROW but no longer doing so. The longer members had been in GROW the more likely it was that they had ceased using these other resources, raising the possibility that GROW participation substitutes for the use of such resources. This would have clear implications for the delivery of mental health services and phases 2 and 3 of this study will continue the investigation of this dimension.

GROW membership appears to consist of a number of distinguishable clusters, one of the major clusters appearing to have orientation toward the provision relief from symptoms and another an orientation toward stable supportive relationships. The possibility is raised that the interests of these two clusters may be best served by differing processes within group meetings: processes which encourage behaviour changes for one cluster, and, for another cluster, processes which provide support. As mentioned, the second phase of this investigation will examine group processes.

The finding that GROW is uniform throughout Australia has been substantially confirmed by subsequent studies in South Australia (Burgess & Anstey, 1987) and Western Australia (Shannon & Morrison, 1990). This will enhance the external validity of further phases of this investigation which, for most data, will draw samples from two states, Tasmania and Victoria.

## **CHAPTER 6**

### **PHASE 2: GROW'S PROCESSES AND GROUP CLIMATE**

## 6.1 Introduction

The second phase of the study investigated processes which might contribute to the achievement of the organisation's stated goals: to provide a means for the rehabilitation of those who have suffered mental breakdown, a means for the prevention of breakdown, and "a popular school of life and leadership for mental health" (GROW, 1983 p.1). As suggested earlier, the processes could be expected to be reflected in the social climate of the group so that the study proposed to measure members' perceptions in terms of dimensions of the group environment as well as obtaining a direct report of the helping processes which members discern.

GROW developed from the meetings of people who had been seriously mentally ill and, although many who now attend GROW may never have had such an illness, as shown in the first phase of this investigation, the organisation still has a large proportion of members who have used other mental health services. It might be expected therefore to provide an alternative or addition to the use of other mental health and rehabilitation resources including professional help and medication. Indeed, as noted above, data already collected suggests this conclusion.

Although analysis of members' reported reasons for joining GROW indicated that a large proportion (cluster 1 above) were concerned to change behaviour in a way which could be described as the alleviation

of symptoms, there is no clear indication from the results of the first phase of this investigation of the status of members' mental health. Do they indeed display symptoms of mental illness? As noted, the question of where GROW members stood on a mental-health: mental-illness continuum would be a question of particular concern to funding agencies.

It was planned, therefore, to measure GROW members' symptomatology on a scale which would allow comparison with other populations.

Effective processes in GROW groups would have to provide, for those who are or have been mentally ill, the opportunity to alleviate or eliminate symptoms of that illness. Further, even for those who have never been mentally ill, membership of GROW is predicated on the assumption that those attending have some problem which they would want to change. The first of the "twelve steps of personal growth" on which the GROW program is founded participants are expected to affirm that they "admitted [they] were inadequate or maladjusted to life" (GROW, 1983, p.5). "These words can be understood to mean mentally and/or socially and/or spiritually out of tune with reality" (p.3).

As well as reduction or elimination of symptoms, criteria by which the effectiveness of such a programme is evaluated should include a measure of the satisfaction of the clients with the process and outcome as they perceive it.

A second clear claim of GROW is that the organisation provides a "caring and sharing community" (p.1) in which change may occur. One of GROW's principles states: "As egocentricity is the cause of stunted growth and disintegrating personal life, decentralisation from self and participation in a community of persons is the very process of recovery or personal growth" (GROW, 1983 p.25). The first study in this investigation found that many GROW members gave reasons relating to inadequate or dysfunctional social networks for their participation. Whether GROW's meetings provide the context for improving social networks and improving the quality of social support is a question relative to its effectiveness.

As noted by Shumaker and Brownell (1984), "confusion remains regarding what social support *is*, what it is *not*, how it *operates*, and what are its real and potential *short-* and *long-term* effects." (p.17; authors' italics). In this regard, despite some important contributions (e.g. Sarason & Sarason, 1985; Barrera, 1986; House, Umberson & Landis, 1988; Heitzmann & Kaplan, 1988; Sarason, Shearin, Pierce & Sarason, 1987) little has changed since 1984 except, perhaps, the complexity of social support is better appreciated. However, Shumaker and Brownell go on to define social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient"(p.17), and it is in these terms that the aspect of social support in GROW's processes (and, in phase 3, outcome), is to be assessed.

Emphasis is placed on the perception of the recipient of support. While it is clear that perceptions of support, received or available, are not necessarily the same as either the effects of support received (Shumaker & Brownell, p.19) nor objectively determined support given or available, measurement of perceptions of recipients will help "tap individuals' psychological representations of their support systems" (Cohen & Syme, 1985, p.12). Such psychological representations, Cohen and Syme, have suggested, are better predictors of health and health behaviour than objective structural relations, (p.12) and as such would be more appropriate to present purposes.

This study looks for evidence that GROW does provide (a) a climate in which change is encouraged; (b) a programme the members' perception of which makes it a means for rehabilitation and an alternative to the use of other mental health resources; (c) permanent problem-oriented social support for people whose supportive network is otherwise impoverished.

As mentioned above, the cross-sectional nature of the first phase of this research did not provide any indication of the length of time members remained in the organisation or of the number of people attending over time. Attendance at GROW meetings has not been recorded as a matter of routine. It has been argued by GROW leaders that keeping records applies covert pressure on members to attend, detracting from the uncoerced and voluntary quality which is necessary for the programme to be maximally effective. A second



argument against the keeping of attendance records has been that the guarantee of anonymity and confidentiality would be breached (GROW, 1989, p.3).

A proposal put to the national leadership that a record of attendance be kept as part of this study was at first resisted. However, after lengthy negotiations a formula was agreed upon which allowed the recording of attendance within group meetings for a limited period, the results to be open to the author only after recorded names had been deleted.

## **6.2 Measures**

### **6.2.1 Group Process and Environment**

(a) To study the group climate and the processes in GROW, the Group Environment Scale, (GES), (Moos, 1986) and the Helping Process Questionnaire, (HPQ), (Wollert, 1986) were used.

The GES is one of nine social climate scales developed by Moos in 1974. It has extensive psychometric backing, and norms established by the measure's developers in America have been widely accepted in comparative studies in the U.S. and other western countries (Toro et al., 1987; Lavoie, 1981). The scale uses a 90-item true/false questionnaire comprising ten subscales designed to measure the social-environmental characteristics of task-oriented, social, psychotherapy and mutual support groups. Internal consistencies for

the ten subscales are reported to range from moderate (Cronbach's  $\alpha = .62$ ) to substantial ( $\alpha = .86$ ). The subscales measure related but distinct aspects of group social environment with average inter-subscale correlations from .30 to .53. Test-retest reliability at a month interval was reported to range from .65 to .83 and considered to be acceptable (Moos, 1986 p.6).

The HPQ is a series of 27 statements, derived from descriptions of help-giving activities observed in a number of differing mutual help groups (Levy, 1976; 1979). Each statement thus reflects a different helping process, which group members rate on a five-point scale, with 1 defined as "an inaccurate description (this is something that rarely happens; is not at all like our group)" and 5 defined as "a very accurate description (this happens often; it gives a good idea of what our group is like)". Although, in recognition of methodological problems, psychometric precision is not claimed for the measure (Levy, 1979, p.243), it has been used in assessing a number of diverse groups (Levy, 1979; Wollert, Levy & Knight, 1982; Wollert, 1986; Nicholaichuk & Wollert, 1989), allowing a comparison of GROW's processes with other groups and a useful adjunct to GES data.

The questionnaire was trialed with members of GROW in Tasmania and minor adjustments were made to the wording to allow it more readily understood. The version of the HPQ used was that used by Wollert (1986) with one item (group goal setting, which had been in the original instrument) omitted.

### 6.2.2 Symptom Check List

(b) To measure whether GROW members might be clients with a need for mental health resources and might benefit from rehabilitation, the Symptom Check List (SCL-90-R) (Derogatis, 1983) was used. It is a 90-item self-report symptom inventory designed primarily to reflect the psychological symptom patterns of psychiatric and medical patients, each item rated on a five-point scale of distress ranging from "not at all" at one pole to "extremely" at the other. The SCL90-R is scored and interpreted in terms of nine primary symptom dimensions and three global indices of distress.

A somatization (Som) dimension reflects the distress arising from bodily dysfunction; an obsessive-compulsive (O-C) dimension reflects symptoms that are highly identified with the clinical syndrome of the same name; an interpersonal sensitivity (Int) dimension focuses on feelings of personal inadequacy and inferiority; a depression (Dep) dimension reflects a broad range of symptoms of depression; an anxiety (Anx) dimension includes symptoms of clinically manifest anxiety; a hostility (Hos) dimension reflects thoughts, feelings and actions characteristic of anger; a phobic anxiety (Phob) dimension is defined as a persistent fear response, irrational and disproportionate to the stimulus; a paranoid ideation (Par) dimension represents paranoid behaviour fundamentally as a disordered mode of thinking; and a psychoticism dimension (Psy) includes symptoms commonly associated with psychosis.

The function of the global indices, which are of particular relevance in the present context, is to communicate in a single score the level or depth of an individual's psychopathology. Each global measure reflects a different aspect of psychopathology (Derogatis, 1983). The global severity index combines information on numbers of symptoms and intensity of perceived distress; the positive symptom distress index is a pure intensity measure; and the positive symptom total is a count of the number of symptoms the respondent reports as distressing to any degree.

Norms established on American populations of in-patients, out-patients and non-patients have been used in studies in Australia and other countries outside the U.S. (Kinzie & Manson, 1987; Piersma, 1987) and while scores for some countries differed significantly from the U.S. scores, the Australian scores were remarkably similar.

### **6.2.3. Social Network Measures**

(c) To measure the nature and extent of GROW members' social network the Perceived Support Network Inventory (PSNI) (Oritt, Paul & Behrman, 1985) and the Social Support Appreciation scale (SS-A) (Vaux, Phillips, Holly, Thomson, Williams & Steward, 1986) were used.

As well as a measure of the size of the subjects' network as they perceive it, the PSNI provides a rating on a seven-point scale of six dimensions of support afforded by members of respondents' perceived

network, identified as friends, family members, professionals or self-help group members. (It is noted that the term "self-help" is used on the PSNI printed form, contrary to the convention of this study to refer to mutual help. The terms are treated as synonymous.)

The six dimensions are: (1) the extent to which the subject actively solicits support from network members in times of stress, (initiation); (2) the perception of how readily available network members are for support in times of stress, (availability); (3) satisfaction with support in terms of the effectiveness in producing relief in times of stress, (satisfaction); (4) the number of types of support a subject expects to be able to receive from a network member in times of stress, (multidimensionality); (5) the extent to which the subject believes reciprocity exists in relationship with a network member, (reciprocity); and (6) the extent to which the subject perceives conflict between himself or herself and network members, (conflict). (Oritt, et al., 1985, p.568).

Test-retest reliability for the PSNI has been reported for the total score and subscale scores at correlations between .72 to .88, and an internal consistency alpha coefficient at .60. When the perceived network size score was excluded the alpha increased to .77. Comparison was made with the Perceived Social Support Inventory (Procidano & Heller, 1983) and the Inventory of Socially Supportive Behaviors (Barrera, Sandler & Ramsay, 1981) to obtain an estimate of construct validity, and correlations ranged from .21 to .57 with corresponding PSNI dimensions (Oritt et al, 1985).

The derivation of PSNI is based on a definition of social support which focuses on interactions "during times of stress" (Oritt et al, 1985, p.567). This definition differs from that of Shumaker and Brownell (1984) quoted above and adopted for the purposes of this study, and it was considered possible that such a definition might limit the measurement of unstressed support ("the exchange of resources between two individuals...": Shumaker & Brownell, 1984, p.11) which might be significant for GROW members. For this reason an attempt was made to broaden the measurement of social support by the use of the SS-A scale.

The SS-A (Vaux et al., 1986) was developed specifically to measure the subjective appraisal of support which, its developers contend (p.197) is particularly important in regard to psychological well-being. The 23-item scale is based on the theoretical position subsumed under a definition attributed to Cobb (1976): "beliefs that one is loved, respected, and esteemed by and involved with family, friends and others" (Vaux et al., 1986, p.200). It provides three subscales: a subjective four-point rating of the appreciation of support afforded by family, by friends, and a total appreciation of support by family, friends and others. Vaux et al. report good internal consistency with mean Cronbach alpha coefficients of between .90 and .80 for five student samples and five samples drawn from the wider community. Family and friends subscales were moderately correlated (p.206). Comparison with other measures allow Vaux et al. to report that "...our findings with regard to construct validity of the SS-A appear to have good external validity

with respect to persons, methods of data collection and operationalization of validating constructs" (p.215).

For purposes of the present study norms were established by the author for the SS-A from a heterogeneous population of 326 (58% women) in Tasmania drawn from industrial workers and students. A comparison of scores of students and others revealed no significant difference.

#### **6.2.4 Attendance Record**

Forms were designed to allow for the recording of attendance of GROW members over a period of up to 18 weeks, their names to be written on a strip to the left of a perforation. Provision was made for recording the date of first attendance for each member. Instructions to group organisers were printed on the forms and a two-letter code to allow identification of the group was written on each form. A separate row of recording squares for each member provided individual attendance records.

Copies of the measures are included in Appendix B.

### 6.3 Method

Three methods of data collection were employed.

(1) The GES was forwarded through the GROW organisation to 60 of the 91 groups operating in Victoria and Tasmania. Twelve copies of the questionnaire were sent to each group in the sample with the request that all members be encouraged to complete one at a group meeting. Return stamped and addressed envelopes were included and organisers, in a covering letter, were asked to return all questionnaires, completed or not. This procedure had been discussed with state leaders before the mailing and group organisers had been alerted to it through the organisation's internal communication.

(2) The author visited 27 regular GROW group meetings in Victoria and Tasmania to obtain the HPQ, SCL-90-R, PSNI and SS-A data and questionnaires were completed in his presence. Basic demographic data and prior and current use of professional help and medication for the problems which brought members to GROW were also obtained.

(3) Attendance record forms were forwarded to the organisers of 40 groups distributed nationwide in approximate proportion to the numbers of groups revealed in the phase 1 survey: (NSW, 11 groups; Vic., 9; SA, 6; Q, 6; WA, 5; Tas., 2; NT, 1). The group organisers were instructed on the forms to keep records of members' attendance for at least 13 weeks, to detach the names of GROW members from the forms



and to send them by a due date to state organisational headquarters. They were there to be checked to see that they did not contain information which would identify members and then to be forwarded to the author.

Groups in the three samples were selected to approximate the distribution of groups throughout Australia in terms of group location (city, suburban, large and small country towns) and meeting times (morning, afternoon and evening).

## **6.4 Results**

### **6.4.1 Demographic Data**

Demographic data was compared with corresponding data from Phase 1 of the study. No significant differences had been detected among state samples in the earlier survey and no significant differences were detected between samples in the present study and the previous study. Nor were there significant differences between the two studies in the prior and current use of professional help or medication.

### **6.4.2 Group Environment Scale**

Useable responses were returned from 234 individual members of 45 groups (75%).

GES scores were compared by t-test with norms established by Moos (1986) for social, task-oriented, and psychotherapy and mutual-help groups, as well as combined test norms. Means and standard deviations with t-test significance are reported in Table 6.

GROW group environment as measured by GES was significantly different from the test's combined norms on all but two of the subscales. Values were negative for the anger-aggression and innovation subscales indicating the perception of significantly less of these characteristics in GROW groups than the norm. Multiple correlations indicated that GROW differed more markedly from the norms of the psychotherapy and mutual-help sub group than from the combined norms.

**Table 6 - Means and standard deviations for GROW and established norms for Group Environment Scale (Moos, 1986).**

	GROW (n=45) Mean(SD)	Combined Norms (n=148) Mean(SD)	Social Recreat'l (n=57) Mean (SD)	Task Oriented (n=56) Mean (SD)	Psychotherapy Mutual Help (n=35) Mean (SD)
Cohesion	7.89 (0.74)	6.05** (1.77)	6.27** (1.64)	6.19** (1.69)	5.47** (1.97)
Leader support	7.79 (0.99)	6.21** (1.63)	6.80** (1.47)	6.16** (1.64)	5.32** (1.43)
Expressiveness	5.72 (1.03)	5.48 (1.57)	5.30 (1.53)	5.37 (1.41)	5.97 (1.78)
Independence	7.46 (0.59)	6.08** (1.43)	5.64** (1.60)	6.46** (1.16)	6.17** (1.32)
Task Orientation	7.80 (0.91)	5.60** (1.61)	5.49** (1.28)	6.32** (1.40)	4.61** (1.83)
Self Discovery	6.66 (0.94)	4.83** (1.95)	4.44** (1.70)	4.18** (1.68)	6.49 (1.79)
Anger & Aggression	1.83 (1.15)	4.81** (1.83)	5.12** (1.79)	4.20** (1.65)	5.26** (1.90)
Leader control	5.19 (1.19)	4.91 (1.96)	6.12* (1.77)	4.82 (1.48)	3.07** (1.39)
Innovation	3.89 (1.21)	4.87** (1.59)	4.11 (1.54)	5.07** (1.19)	5.79** (1.63)

Significant difference from GROW, by t-test

\*  $p < .01$

\*\*  $p < .001$

### 6.4.3 Helping Process Questionnaire

Useable responses were obtained from 151 members of 27 groups.

A summary score was derived from the HPQ data by disregarding the middle (neutral) score, subtracting the negative score from the positive score and expressing the result as a percentage of the possible score. Thus a score of 100 would mean that all respondents considered the statement to be a highly accurate description of the group's activities; a score of -100 would mean that all respondents considered the statement to be not at all accurate as a description of the group's activities. HPQ results were ranked according to transformed scores (Table 7).

**Table 7: Helping Process Questionnaire Transformed Mean Scores (n=151 in 27 groups).**

Mutual affirmation	84.5	Justification	38.5
Empathy	72.5	Offering feedback	38.0
Instilling hope	66.3	Reflection	24.2
Behavioural prescription	62.5	Instilling confidence	18.7
Explanation	60.5	Modelling	12.5
Requesting elaboration	59.6	Consensual validation	9.6
Catharsis	54.5	Confrontation	8.9
Positive reinforcement	53.0	Discrimination training	8.0
Self disclosure	53.0	Behavioural proscription	-1.0
Check-in	47.0	Behavioural rehearsal	-7.5
Personal goal setting	46.5	Normative reference	-22.2
Normalization	46.0	Requesting feedback	-42.5
Functional analysis	45.0	Extinction	-45.4
Punishment	-55.0		

To allow comparison with published results of other studies using the HPQ, (Levy, 1979; Wollert et al., 1982; Wollert, 1986) mean scores were calculated for individual items (Table 8). Because the reported results were means of group means, inferential statistical analysis was not warranted. A systematic difference appears to be present in that all GROW mean item scores were greater than the combined mean item scores of the other mutual help groups studied. The average difference in scores was +.54 (SD .34). Items with more than one standard deviation difference ( $t=2.28$ ,  $df=26$ ,  $p<.01$ ) from the other groups in a negative sense (i.e. processes were less characteristic of GROW than the other groups) were: instilling confidence ("Members assure one another that they are capable of handling their own problems"); discrimination training ("When a group member describes a situation happening at the present time as similar to situations which happened in the past, other group members point out in what ways these situations or emotional reactions are different"); extinction ("When a member says or does something of which the group disapproves, the group members ignore the person's behaviour"); and punishment ("When a member does something the group disapproves of, the group criticises this behaviour or in some way punishes the person acting in this way").

**Table 8: Means of mean ratings of mutual help groups on the Helping Processes Questionnaire in GROW compared with three non-GROW studies.**

Process	GROW groups	Wollert (1986)	Levy (1979)	Wollert et al (1982)	Combined non-GROW means
Mutual affirmation	4.69	4.14	3.94	3.79	3.96
Empathy	4.45	4.02	4.20	4.18	4.13
Instilling hope	4.31	3.70	3.82	3.91	3.81
Behavioural prescription	4.20	3.22	3.40	3.55	3.39
Explanation	4.20	3.56	3.89	3.77	3.74
Requiring elaboration	4.14	3.14	3.57	3.55	3.42
Positive reinforcement	4.09	3.36	3.66	3.67	3.56
Self disclosure	4.05	3.35	3.67	3.26	3.43
Catharsis	3.99	3.32	3.59	3.25	3.39
Check-in	3.98	3.70	3.83	3.62	3.72
Normalization	3.92	3.66	3.39	3.36	3.47
Functional analysis	3.91	3.02	3.30	3.13	3.15
Personal goal setting	3.84	2.66	3.61	3.45	3.24
Justification	3.81	3.24	3.35	3.56	3.38
Offering feedback	3.69	2.78	2.01	1.99	2.26
Reflection	3.41	2.88	3.17	2.98	3.01
Instilling confidence	3.40	3.36	3.41	3.30	3.36
Modelling	3.28	2.54	2.25	2.33	2.37
Discrimination training	3.17	2.70	3.30	3.12	3.04
Confrontation	3.12	2.43	1.65	1.58	1.89
Consensual validation	3.09	2.43	2.92	2.84	2.73
Behavioural proscription	2.96	2.16	2.62	2.82	2.53
Behavioural rehearsal	2.89	1.98	1.79	1.76	1.84
Normative reference	2.52	1.70	2.39	2.67	2.25
Requiring feedback	2.10	1.74	1.76	1.63	1.71
Extinction	2.09	1.86	2.17	2.18	2.07
Punishment	1.82	1.53	1.65	1.93	1.70
Item mean	3.52	2.90	3.06	3.00	2.98

Items with more than one standard deviation difference ( $p < .01$ ) from the other groups in a positive sense (i.e. processes were more characteristic of GROW than of the other groups) were: offering feedback ("Group members let other members know how they feel about them. This information is shared face to face"); confrontation ("Group members challenge one another to explain themselves or account for their behaviour"); and behavioural rehearsal ("When a personal problem is brought up by a member, other group members suggest how the person might act to handle the problem, and then ask the person to practice doing what is suggested in the presence of the group"). The score for the first two of these processes was more than twice the value of the standard deviation above the mean.

#### **6.4.4 Symptom Check List**

Useable responses were obtained from 166 members of 27 groups.

SCL-90-R scores were compared by t-test with test norms for non-patients, in-patients and out-patients of psychiatric units. Means and standard deviations are reported in Table 9.

**Table 9 - Means and standard deviations for GROW and established norms (raw scores) for SCL-90-R (Derogatis, 1983).**

	GROW (n=166)	Non-patient (n=974)	Psychiatric out-patient (n=1002)	Psychiatric in-patient (n=313)
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Somatization	0.65 (0.70)	0.36 (0.42)	0.87 (0.75)	0.99 (0.84)
Obsessive-compulsive	0.95 (0.80)	0.39 (0.45)	1.47 (0.91)	1.45 (1.00)
Interpersonal sensitivity	0.90 (0.85)	0.29 (0.39)	1.41 (0.89)	1.32 (0.97)
Depression	0.97 (0.85)	0.36 (0.44)	1.79 (0.94)	1.74 (1.08)
Anxiety	0.80 (0.82)	0.30 (0.37)	1.47 (0.88)	1.48 (1.05)
Hostility	0.56 (0.71)	0.30 (0.40)	1.10 (0.93)	0.94 (0.95)
Phobic anxiety	0.44 (0.68)	0.13 (0.31)	0.74 (0.80)	0.96 (1.03)
Paranoid ideation	0.69 (0.78)	0.34 (0.44)	1.16 (0.92)	1.26 (0.98)
Psychoticism	0.52 (0.62)	0.14 (0.25)	0.94 (0.70)	1.11 (0.85)
GSI	0.76 (0.63)	0.31 (0.31)	1.26 (0.68)	1.30 (0.82)
PSDI	1.86 (0.71)	1.32 (0.42)	2.14 (0.58)	2.15 (0.73)
PST	32.96 (20.78)	19.29 (15.48)	50.17 (18.98)	50.03 (22.40)

**Significant difference from GROW, by t-test  
p<.001 for all values**

Scores were significantly different on every dimension from non-patient, in-patient and out-patient norms (Derogatis, 1983), but the sign of the difference was positive for non-patients and negative for out-



patients and in-patients. Examination of the means reveals that GROW members' scores were nearer those of psychiatric out-patients and in-patients on the global severity index and the positive symptom distress index, but closer to the non-patient norms on the positive symptom total measure.

When men and women were considered separately, the men in the sample had scores which indicated significantly greater psychiatric symptomatology than the women (Global severity index  $t=4.11$ ;  $p<.001$  on two-tailed test). This was true for all dimensions measured except for the somatization dimension (distress arising from perceptions of bodily dysfunction) and the global index of positive symptom distress.

#### **6.4.5 Perceived Social Network Inventory**

Useable responses were obtained from 155 members of 27 groups.

PSNI data were analysed to determine the respondents' perception of the composition of their network and t-tests applied to determine significant ( $p<.05$ ) differences of their rating of support from the various classes of network members.

Of the 155 respondents 81 (52%) included fellow GROW members in their support network: i.e. those people to whom they would turn if they needed support and help in times of stress. This is fewer than nominated family members including spouses (74%), friends (64%), or

professionals, including doctors, lawyers, religious leaders (57%). However, self-help group members were rated significantly more highly than network members as a whole on five of the six dimensions tapped. Satisfaction with the help received in times of stress was greater; provision of help or support when asked was more reliable (availability); serious conflicts were less likely; more categories of support could be expected, though not as many categories as could be expected from family or other friends (multidimensionality); and a greater degree of reciprocity in the relationship was expected, greater also than with other friends. The only negative relationship was on the dimension of initiation; that is respondents would be more likely to seek help from other members of the network before seeking help from fellow GROW members.

#### **6.4.6 Social Support - Appreciation**

One hundred and thirty eight responses from members of 27 groups were scored and contribute to the results. SS-A scores were compared by t-test with established norms mentioned above (Section 6.2.3) (Table 10).

**Table 10: Social Support - Appreciation (Vaux et al, 1986):  
GROW members' mean scores (and standard deviations)  
compared by t-test with scores for a non-member sample.**

Variable	Ss Mean (SD) (n=138)	Norm Mean (SD) (n=327)	t-score
Total	2.019 (0.46)	1.829 (0.38)	4.222*
Family	2.034 (0.60)	1.712 (0.49)	5.855*
Friends	1.844 (0.52)	1.820 (0.45)	0.436

\*p = <.001

Note: High score represents less appreciation

GROW members understood themselves to be significantly less well supported by members of their families than did the non-members and that the social support they received overall was significantly worse than the norm. There was no significant difference, however, in members' appreciation of the support of their friends.

High global severity indices of the SCL90-R correlated significantly with a total SS-A score (Pearson's  $r=.34$ ;  $p<.001$ ), indicating less appreciation of the support received from friends, family and others. In other words, the more severely disturbed subjects were, the less they judged the support of others to be.

The appreciation of the support of friends was significantly correlated with members' time in GROW ( $r=.19$ ;  $p<.02$ ): the longer

members remain in GROW the more supportive they judge their friends to be.

#### 6.4.7 Attendance

Of the 40 groups from whom data was sought on attendance over three months between May and August 1986, 31 (77.5%) returned useable records. The sample recorded a minimum of 13 meetings and a total of 491, an average of 15.8 meetings per group (Table 11).

**Table 11: Attendance at a national sample of 31 GROW meetings over 3 months.**

NMeets	Frequency	Percent	Cum.Freq.	Cum%	Mem/Attend
1	121	26.4	121	26.4	121
2	57	12.4	178	38.8	114
3	40	8.7	218	47.5	120
4	24	5.2	242	52.7	96
5	17	3.7	259	56.4	75
6	18	3.9	277	60.3	108
7	21	4.6	298	64.9	147
8	20	4.4	318	69.3	160
9	17	3.7	335	73.0	133
10	16	3.5	351	76.5	160
11	16	3.5	367	80.0	171
12	21	4.6	388	84.6	252
13+	70	15.3	458	100.0	910
					2567

Of the whole sample, 9.4% attended 96-100% of the meetings, 32% attended at least half of the meetings. Record was also kept of when members first attended meetings and of those who had first attended in the previous six months, 8% attended all meetings, 33.5% attended at least half of the meetings recorded.

A comparison of members recently joining with members who had joined more than six months previously revealed no significant difference, but 121 members (26.4%) attended one meeting only in the three months sampled; 178 members attended only once or twice. The 31 groups sampled averaged 15.129 different persons attending at least one meeting. Average group size was 5.23 members.

## 6.5 Discussion

GROW does not encourage the expression of negative feelings. From data relating to group environment and processes, the most striking feature of all the comparisons with norms is the markedly lower GROW score on the anger-aggression subscale of the GES. Moos (1986) described this dimension as "the degree to which the group tolerates and encourages open expression of negative feelings and intermember disagreement" (p.2).

GROW does not encourage change in the group environment. This is reflected on the innovation dimension of the GES: "the extent to which the group facilitates diversity and change in its own function

and activities"(p.2), a dimension which suggests a structured environment not readily responsive to moves for structural change.

The only dimension on the GES not significantly different from the combined norms is that of expressiveness: "the extent to which freedom of action and expression of feelings are encouraged"(p.2).

Other than the three dimensions noted above, all GROW GES scores are significantly higher than Moos' combined norms. Furthermore, this pattern is evident in all but two dimensions (self-discovery compared with the psychotherapy and mutual-help subgroup norms, and leader control compared with the task-oriented subgroup norms) in comparison with norms established by Moos for subgroups.

Consideration of the sign of the significantly different dimensions emphasises the difference between GROW and the groups in the normative sample.

Moos groups the subscales of the GES into dimensions of relationships, personal growth, and system maintenance and change. In these terms, GROW's principal strength would appear to lie in encouraging positive relationships. The personal growth dimension is also stronger than in the normative sample, with task orientation being the subscale most highly weighted, but the inclusion of the anger-aggression subscale in this dimension counts heavily against weight given it by members. The system maintenance and change dimension

in GROW is also important in the members' view, but more in regard to "maintenance" than "change" as indicated by the lower score in the innovation subscale.

This picture is supported by the results of the HPQ. Processes which reflected positive in-group relationships were most commonly identified as being present in GROW groups while processes which reflected less on relationships or reflected negative in-group relationships were more commonly said not to be present.

It is noted that the two processes most commonly agreed as accurately describing GROW groups, mutual affirmation and empathy, are clearly relational processes while punishment and extinction, most commonly perceived as inaccurate in describing GROW groups are likely to involve the expression of negative feelings. This reinforces the conclusions drawn from the GES results.

Comparing diverse mutual help groups with which he had used the HPQ, Wollert (1986) noted that there appeared to be a core of processes which groups commonly use in attempting to meet their members' needs. Levy (1979) had earlier made a similar observation on the basis of a comparison of a smaller number of groups: "they are more similar to each other than different in how they engage in the process of helping their fellow members" (p.270). Data from this present study support such a conclusion.

Having said that, the differences of GROW's processes as perceived by the membership from perceived processes of other groups is of interest. While GROW conforms to the pattern of other groups in rating processes of mutual affirmation and empathy at the top of the list and punishment and extinction at the bottom (these last two processes even less characteristic of GROW than of other groups), processes of confrontation and offering feedback which other groups rank among the lowest in frequency are each promoted several places in the hierarchy by GROW members. The difference between GROW and the other groups on these dimensions is more than two times the standard deviation above the mean.

Levy (1979) suggested that the processes of confrontation and those involving feedback may "require a higher level of therapeutic competence for their effective use than is likely to be found among nonprofessionals"(p.265). GROW, however, specifically encourages these processes within the context of its meetings (GROW, 1989, pp.69-70). The encouragement in these processes is, however, couched in terms that emphasise sensitivity and mutuality. For example, with reference to giving feedback, members are to "freely and generously reveal to each GROWer his or her 'hidden splendour' and loveableness" (p.69); with reference to confrontation, members are encouraged to "confront persons with a truthful challenge - in a frank and friendly way - which is geared to their necessary self-activation" (p.70), and to "care enough to challenge each other to change and, beyond that, to continue to grow" (p.70).



The finding that GROW, with greater frequency than other mutual help groups, expects these processes, supports the theory that GROW actively works to bring about desired changes in the lives of its members through the mutual recognition and articulation of the salient features of each other's problems and solution to those problems.

SCL-90-R data suggest that many of the GROW population could be expected to use some mental health resource as a means to change. They are more disturbed than non-patients but less disturbed than either in-patients or out-patients of psychiatric hospitals. Derogatis (1983) claimed that "the best single indicator of the current level or depth of disorder" provided by the SCL-90-R is the global severity index. This index, together with all the other scores, both global measures and symptom dimensions, are significantly higher (worse) for the sample as a whole than non-patient norms. Comparison of the means, indicates that, in their report of numbers of psychiatric symptoms, GROW members are more like the non-patient norms but that their perception of the symptoms they do report, and their global severity index is more like that of psychiatric out-patients.

The use of other mental health resources is confirmed by members' reports. Of the current sample 84% reported that they had at some time sought professional help for the problems which brought them to GROW (80% in the Phase 1 Australia-wide sample), 88% had at some time taken medication for those problems (79%) and 59% had been

hospitalised for their problems. However only 48% were currently using professional resources and only 52% currently using medication for their problems. It will be recalled that the Phase 1 data provided some evidence that the time of GROW membership is inversely related to professional help sought and medication taken. This data further supports that finding, although the caution suggested earlier (5.3.3 above) must also be applied in interpreting this result.

Results of the PSNI and SS-A reflect on the question of whether GROW provides an effective permanent support network. Although mutual help group members were included less frequently in GROW members' perceived support networks, the quality of support received or expected was significantly more highly rated than that of network members as a whole on five of six measured dimensions. In this respect mutual help group members fared better than any other class of network members.

Further, evidence from the measure of the appreciation of support suggests that although GROW members generally see themselves as poorly supported, and more severely disturbed persons feel less well supported than others, the longer they remain members of GROW the more likely it is that these impressions will change.

With regard to the survey of attendance, a drop-out rate of 26.4% after one meeting appears high but is not markedly different in proportion from those reported by Taube, Burns and Kessler (1984) for attrition rates among patients of private psychologists and psychiatrists

nor from drop-out rates from voluntary mental health programmes (Yalom, 1966). Interestingly, the proportion is almost exactly that reported by Toro (1987) in his study of the first GROW groups established in Illinois.

The average group size of 5.23 members per meeting is low but within the range for intensive personal interaction and support (Hansen, Warner and Smith, 1980).

The open approach GROW takes to membership and the limited time-span of this attendance survey, together with untapped variables such as possible seasonal attendance differences, restrict reliability of extrapolations. However, with this caution, some estimates of the overall number of persons involved in GROW is now possible.

On the basis of Phase 1 data, 20.5% of people at a meeting had been members for three months or less. On this data, for 313 groups Australia-wide, 7647 different people would attend at least one meeting in the course of a year.

By another estimate, extrapolating the data from this attendance survey to the whole of GROW in Australia shown by the Phase 1 survey, there would be more than 80,000 meeting-attendances a year. Of these, about 5700 attendances would be by people attending once or twice only.

GROW group meetings typically last two hours (GROW, 1983, p.1). Thus in actual meeting time the national organisation accounts for at

least 160,000 contact hours for its membership. Added to this are the frequent meetings for member-leaders, residential weekends, social functions and informal between-meeting contacts among members. In total this must, in terms of time, add up to a considerable impact on the lives of a large number of troubled people.

In summary, GROW groups are seen by their members as being strongly cohesive with a strong leadership and an organisational structure not easily changed. They provide the opportunity for strongly supportive relationships. They are committed to encouraging personal growth and change in a way which, for the most part, avoids the expression of negative feelings and intermember disagreement. Processes do not appear to be aimed at the maintenance or change of groups per se; rather the group is maintained by means of strengthening intermember relationships.

Many GROW members have had or have some measure of psychiatric disturbance and see themselves as poorly supported in their social network. The evidence suggests that membership is coincident with a decrease in the use of other mental health helping services and support received from fellow GROW members may contribute to meeting their perceived need.

The provision of rehabilitation after serious mental illness would be consistent with the evidence, but the data did not allow a conclusion in this point.

In terms discussed earlier, both palliative and facilitative support may alternate or be concurrent for different members. The analogy of a supportive family seems appropriate.

While personal changes may be brought about with the use of recognisable cognitive-behavioural strategies (e.g. goal-setting, behavioural prescription etc), the informality of the setting would make further definition, let alone the attribution of outcome to specific strategies, difficult if not impossible. It would seem more appropriate, therefore, to examine changes that may appear in the lives of members over time, in terms of improvement in social support, an increased sense of control, and enhanced quality of life.

These questions will be addressed in the third phase of this investigation.

## **CHAPTER 7**

### **PHASE 3: A STUDY OF EFFECTIVENESS**

## 7.1 Introduction

The first two phases of this investigation have portrayed an organisation with a large and diverse population which purports to have a pervasive influence in the lives of its membership. As suggested above (section 4.4) objectives of such broad sweep as GROW espouses, demand similarly broad outcome measures.

The results of the Phase 2 study suggested that the structure and processes of GROW allowed for strongly supportive relationships. This led to the decision to attempt in the Phase 3 study to measure changes perceived by members in the size and quality of the social support they might experience while GROW members. Further, and even more broadly, if GROW was successful in helping members become "free and whole persons" (GROW, 1989, p.6) changes coincident with membership might be expected in members' perception of the quality of their lives and an attempt would be made in this study to measure such changes.

As mentioned earlier, the particular interest of agencies providing funds supporting GROW might lie in the ability of GROW to provide appropriate alleviation for people who would otherwise consume limited mental health resources. The Phase 2 study provided evidence that GROW membership as a whole were more distressed psychologically than a general population sample, though less so than psychiatric in-patients or out-patients. It was decided, therefore, to

monitor changes, if any, in a measure of psychiatric symptomatology. In addition, a further check would be made, as had been in Phases 1 and 2 of the investigation, of members' use of professional mental health resources and prescribed medication.

One of the obvious disadvantages of using measures as broad as those proposed, it was recognised, was that the host of uncontrolled variables impinging on social support and social network (Cohen & Syme 1985) and, even more, on quality of life (Cheng, 1988), would make causal inference dubious if not meaningless.

It was recognised, therefore, that special emphasis would need to be placed on any methodological strategies which might add strength to conclusions reached. These would include choosing a subject sample which could be equated on as many dimensions as possible with the population of GROW nationwide; taking extraordinary pains to see that the measures to be chosen would be appropriate to the sample population in terms of content and the length of time demanded; ensuring the measures were appropriately and uniformly administered; identifying, if possible, subgroups within the sample in terms of subjects' duration and consistency of participation in GROW, to allow internal comparisons; identifying and recruiting a nonequivalent control group that matched as closely as possible the subject sample; making every effort to retain all members of the subject and control groups for the whole period of repeated measurement. Means to these ends are detailed below.



It is noted that all the proposed measures of outcome are subjective. However, as Heady and Wearing (1981) point out, "Subjective indicators are only subjective in the sense that they reflect people's personal reports of their psychological states. It should not be assumed that they are subjective in the perjorative sense that they are unreliable or invalid."(p.8). Reliability and validity are issues which deserve to be discussed in relation to the measures used, but in so far as GROW's objectives imply improved satisfaction and well-being of its members, self reports have a *prima facie* validity.

## **7.2 Measures**

### **7.2.1 Demographic and GROW Involvement Data**

Questions seeking demographic data and data relating to GROW involvement were repeated from the survey questionnaire of Phase 1. Subjects were asked specifically in regard to their attendance at GROW meetings whether, in the previous two months they had attended GROW regularly (defined as all meetings except when prevented by serious illness or other major impediment), irregularly, (any attendance not measuring up to the "regular" definition), or not at all.

Questions were also asked at each interview about hospitalisation, the use of professional services, and the use of medication for stress, nervous or mental problems.

Copies of the schedule and of all the measures used is appended (Appendix C).

### **7.2.2 Life Events Schedule (LES)**

A life events schedule (Heady et al., 1985; Heady & Wearing, 1986) was checked by subjects at each of the four interviews, the questions asked to relate to the preceding two months. The measure was an adaptation by Heady et al. of the List of Recent Experiences (LRE) developed in Australia by Henderson et al.(1981).

LES was chosen because it had been developed for use within a current Australian population and could be assumed to reflect appropriate cultural values; it contained continuing experiences as well as discrete events; it had been amended to include favourable as well as unfavourable (traumatic) events; and it was brief enough (46 items) to be fitted into a larger battery of measures.

After Heady et al. (1985, p.272) the convention was adopted of assigning to each putatively positive (favourable) or negative (unfavourable) event an unweighted score (+1 or -1), and computing a balance score for each two month interval recorded. The object of the measure was to check against the possibility that events which are understood to have a major impact on quality of life might contaminate other measures of change: the hypothesis was that changes on this measure would not correlate with other measures of change.

### **7.2.3 Psychiatric Symptoms (SCL-90-R)**

The Symptom Check List (SCL-90-R) (Derogatis 1977) which had been used as a measure in Phase 2 was used as a repeated measure to detect changes in symptomatology. The instrument is described in the section on measures in the Phase 2 report above (Section 6.2.2). Unlike the Phase 2 use, however, for Phase 3 the SCL-90-R was read to the subjects as an interview instrument rather than used as a paper and pencil test. Reasons for this change of method are detailed below.

It was predicted that the scores on this measure would be lower (i.e. symptomatology improved).

### **7.2.4 Social Support**

People In Your Life (PIYL) is an instrument devised by Elsa A. Marziali at the University of Toronto for predicting psychotherapy outcome (Marziali, 1987). The scale was developed to assess psychiatric patients' perceptions of the quality and quantity of supportive relationships. It was derived from Henderson's Interview Schedule for Social Interaction (Henderson, Duncan-Jones, Byrne & Scott, 1980; Henderson, Byrne, Duncan-Jones, Scott & Adcock, 1980) and consists of 23 items in two sections. The first section (13 items) includes questions about casual relationships and friends; the second section comprises questions about more intimate bonds.

Each question addresses first the availability (number) of persons in social relationships then the satisfaction with that number and the quality of those relationships. The satisfaction items are rated on a four-point scale from "very satisfied" to "very dissatisfied", thus providing four scores: number of friends and acquaintances (FAV), satisfaction with the number and quality of those relationships (FSAT), the number of intimate relationships (INAV) and satisfaction with the number and quality of those relationships (INSAT).

Good subscale alpha coefficients (between .88 and .94), test-retest reliability, and face, construct, concurrent and predictive validity for the scale are reported (Marziali 1987).

The hypothesis was that scores would increase on the four measures (i.e. improvement).

#### **7.2.5. Quality of Life**

Four scales, drawn from the quality of life literature, were used to measure the subjective appreciation of the subjects of various aspects of their lives. One, Life-as-a-Whole (L-W) single item questionnaire, was chosen to reflect the subjects' overall satisfaction with their lot as they perceived it; a second, Satisfaction with Life Domains Scale (SLDS) was chosen to reflect more specifically on subjects' satisfaction within various domains likely to be of import to GROW members; a third, the Satisfaction With Life (SWL) scale was chosen to reflect the degree to

which subjects achieved their own ideals; and a fourth, the Affect Balance Scale (ABS), was chosen to measure the degree to which events in subjects' lives evoked positive (happy) feelings or negative (unhappy) feelings.

A fifth measure, a Mastery Scale (MS), with origin in studies of locus of control literature was included, which was for the purposes of this study, conceptualised as a dimension of broadly defined quality of life. Discussing the concept of potency as a link in the relationship of stress and coping, Ben-Sira (1985) made the point that "in the psychosocial dimension of stress it is not the demand in itself that makes it a stressor. It is to a great extent the individual's subjective perception that determines the substantiality and the *surmountability* of that demand" (p. 398; italics added). The MS was included to meet this latter point; changes in subjects' belief in their world as a place in which difficulties might be surmounted and their own ability to control events and to surmount difficulties would, it is suggested, change their subjective quality of life.

It was postulated that all five measures could be said to reflect on the quality of the subjects' lives as perceived by them and scores on these scales together would indicate changes over time. The focus of this investigation is on change over time; each individual thus provides his or her own control and absolute measures or measures against other populations is of less relevance. However, because the measures each had its own development and background, each was administered and

scored as a separate scale. Each was adapted in the sense that they were all administered as interview questions and each question was asked in relation to the preceding two-months. The hypothesis was that each measure would show improvement i.e. greater subjective appreciation of quality of life, including more perceived control over events.

The quality of life scales used in the study are appended (Appendix C) and a summary of the measures follows:-

The L-W single item questionnaire was developed by Andrews and Withey and administered as was their Life 3 measure i.e. at the beginning and at the end of each interview, with the score being a simple coded mean. The "faces" version was used in which subjects are asked to point to one of a series of seven faces ranging from a wide smile to a deep frown to indicate their answer, the scale being scored 1 for the broadest smile and 7 for the deepest frown. Extensive information of the reliability and validity of the scale are available and its authors regard it as the best of their global measures of well-being (Andrews and Withey, 1976).

The ABS was developed by Bradburn (1969) and asks ten closed questions, five negative and five positive. The sum provides a balance of experiences associated with positive and negative affect over (in the present study) the preceding two months and is thus an average measure of mood states. Although Bradburn's scale has been criticised

as confusing frequency with intensity and duration of affect (Diener, Larsen, Levine & Emmons, 1985), Cheng (1988) argued that scales that measure average levels of affect are appropriate for programme evaluation: "One may conceptualize one's intervention as to (indirectly) increase the probability with which the client experiences positive feelings over negative ones" (p.126).

More specific than the life-as-a-whole question, the measure also has some bearing on desire for change: it is suggested that the more negatively one evaluates one's life, the more likely, one is to want to change it.

The SWL scale, developed by Diener and his associates, (Diener, Emmons, Larsen & Griffith, 1985), was designed to focus on the cognitive-judgmental aspect of subjective well-being. It does not, it is claimed, tap related constructs such as positive affect or loneliness. The authors showed the measure to have favourable psychometric properties, including high internal consistency and high temporal reliability. It consists of five items, each a positive statement scored on a seven-point scale from "strongly agree" to "strongly disagree", the satisfaction score being a sum of the item scores with a possible 35.

The SLDS has been developed by Baker and Intagliata in the course of their evaluation of community support systems for psychiatric patients (Baker & Intagliata, 1982). Andrews and Withey's code of seven faces (as in the L-W questionnaire above) was used. The scale

asks subjects to pick the face that best expresses their satisfaction with 15 life domains relating to Flanagan's (1978) five categories: physical and material well-being; relations with other people; social, community and civic activities; personal development and fulfillment; and recreation. Although psychometric data is not reported for SLDS, the authors reported a significant correlation with Bradburn's ABS ( $r=.64$ ) and that, when scores of a client sample were "related to other client data, the results were generally consistent with those reported in the [quality of life] literature" (p.77).

The test was scored by subtracting the sum of dissatisfaction (one point for the broadest smile, seven for the deepest frown) from the possible dissatisfaction score.

Baker and Intagliata's cogent reasons for using such a measure for evaluating community mental health systems cited above (section 4.4) were considered to be appropriate to the present study. Whether or not there were observable changes in the physical circumstances relating to the 15 life domains referred to in SLDS, movement in the direction of GROW's objectives might be expected to improve SLDS scores.

A Mastery Scale (MS) was administered to measure the degree of control subjects considered they had over their experience and events in their world. It was decided to limit the measure to eight items to allow it to be accommodated within the considerable battery of measures already assembled.



The items were selected to correspond to the four factors Collins (1974) identified from an analysis of the Rotter (1966) scale: reflecting perceptions of a difficult-easy world, a just-unjust world, a predictable-unpredictable world, and a politically responsive-unresponsive world. In Rotter's terms, four of the items related to internal locus of control and four to external locus of control. Four of the items were stated positively, and four negatively and scored (unlike Rotter's forced-choice format; see Ashkanasy, 1985) on a four-point agree-disagree scale. Wording of the scale items were trialed with GROW members in Tasmania and appropriately amended. Cronbach's coefficient alpha was calculated at .52 indicating borderline reliability of the measure (Nunnally, 1967).

### **7.3 Method**

A longitudinal study of a sample 102 GROW members in Tasmania and Victoria was undertaken as the third phase of the investigation. A non-equivalent control sample of 40 people who had had no contact with GROW but matched members of the sample by certain criteria was recruited in Melbourne. (The control sample is described later.)

The GROW members were chosen from groups matching the pattern of group meetings throughout Australia in terms of location and meeting time, as had been the case in the second phase study. The sample was recruited from GROW group members at GROW meetings in Victoria and Tasmania. The author attended the selected meetings

and, at the meetings' conclusion, explained the research project and asked members to volunteer to be subjects. At first all volunteers were accepted within the constraints of the group matching and progressively selection was applied so that the sample approached the national profile in terms of age and sex. The aim was to recruit 100 subjects: in the event 102 were recruited.

The subjects agreed to meet individually with the author on four occasions: initially, and at subsequent two-month intervals. Discussion with GROW leaders suggested that the six months planned was too short a time span for changes to be measured and the author agreed to seek a further measure at least six months later as a follow-up.

It was decided to collect data by interview and that data be collected by the one researcher for three reasons: first, interviews would meet the difficulty that some of the subjects might be illiterate or have serious reading disabilities; secondly, using one interviewer could ensure uniformity of the measurement procedure; and thirdly, contact with a single individual would lend credibility to a guarantee of confidentiality and anonymity.

Each subject was given a randomly-selected five digit number and only the author kept the key to the numbers for the duration of the study. After the initial interview a card was mailed to subjects a week before their next interview was due, then appointments were made by telephone or personal visit to hold the interview at the subject's

convenience. The interviews were conducted in the subject's home or an agreed venue and each took about one and a half hours. Protocol for the initial interview is in Appendix C.

Results were analysed using SPSS-X MANOVA algorithm (SPSS Inc., 1986) for the repeated measures, the product of the analyses being graphed by Cricketgraph computer programme (Rafferty & Norling, 1987). Means from which the graphs were constructed, together with standard deviations, are included in Appendix C. Differences between the fourth repeated measure and the follow-up measure were tested for significance using SPSS-X paired t-test algorithm. All results with a probability of less than .05 were to be reported, although with a sample of 101 and four or five measures, probabilities of more than .01 deserve to be interpreted with caution.

## **7.4 Results**

### **7.4.1 Sampling and Response Rate**

Times and locations of meetings at which subjects were recruited were subjected to a post hoc analysis which showed no significant differences in the categories (Table 12).



Of the 102 subjects recruited, one (a young male believed to be addicted to alcohol) could not be traced after the first interview. For a variety of reasons (Ss on holiday etc) a further nine of the four repeated-measure interviews were missed (2.2%) and at the follow-up (>six months after Interview 4) 17.2% were missed. Of the 510 possible interviews, 478 (93.7%) were completed and contributed to the results.

Subsequent analysis revealed that the sample was not significantly different from the national GROW population for sex (Chi-square = 2.913;  $p=.088$ ), age ( $\chi^2 = 7.404$ ;  $p=.116$ ), and number of dependants ( $\chi^2 = 1.145$ ;  $p=.766$ ). The sample did differ from the national GROW population, however, in marital and educational status: fewer of the sample were married or widowed and more were single, and fewer of the sample completed high school (Tables 13 and 14).

**Table 13: Phase 3 sample (\*) marital status compared with GROW national population: (Chi-square = 10.002;  $p=.019$ ).**

Married	Widowed	Single	Sep./divorced
34.65%*	2.97%*	39.60%*	22.77%*
45.66%	5.76%	26.39%	22.18%

**Table 14: Phase 3 sample (\*) educational status compared with GROW national population: (Chi-square=8.154; p=.043).**

<High School	Finished H.S.	>High School	Tertiary
54.46%*	16.83%*	16.83%*	11.88%*
46.97%	26.99%	11.10%	14.83%

#### 7.4.2 Attendance

For the whole sample there was no significant trend in attendance over the six months of the repeated measures, but there was a significant decrease ( $p=.0001$  on a two-tail paired t-test) in attendance between the final measure of the series and the follow-up measure.

A distinction could be made (to be used in the analysis of measure results) between those who had attended GROW irregularly or not at all during each of the two-month periods between repeated measurements ( $n=26$ ), and those who had attended regularly for at least one of the two-month periods ( $n=65$ ). Members could also be grouped according to length of time since first GROW membership: <one year,  $n=35$ ; >one year,  $n=55$

### 7.4.3 Use of Other Resources

There was a significant decrease ( $p=.0192$  on a two-tail paired t-test) at the follow-up measure in the number of subjects reporting the use of medication for stress, nervous or mental problems, although no significant trend had been detected over the six months of repeated measures.

Medication for stress, nervous or mental problems had been taken by 89.1% of subjects at some time; 45.5% reported taking such medication at the follow-up measure, a decrease of 43.6%. Ninety-six percent reported having sought professional help at some time for their problems; 53.5% reported seeking such help at the follow-up measure, a decrease of 42.5%. These figures correspond closely to the results of Phase 1 and Phase 2 studies (Table 15).

**Table 15: Decrease reported in use of professional help and medication by members of GROW for stress, nervous or mental problems.**

Study	Decrease Per Cent	
	Professional Help	Medication
Phase 1	43.8*	35.9*
Phase 2	36.0	36.0
Phase 3	42.5	43.6

\*GROW members >2 years

#### 7.4.4 Life Events Schedule

Subjects were divided into two groups: those who had experienced one or more putatively positive event over the six months of repeated measures and those who had experienced no positive events or had experienced one or more negative events. The grouping was tested using the Pearson Correlation algorithm of SPSS-x (SPSS Inc 1986) and showed no significant correlation with any of the scores on the symptomatology, social support or quality of life measures.

Over the four repeated measures there was no significant trend, but at each of the four measures the schedule scores correlated positively with one or more, but not all, of the quality of life measures (Table 16). Correlations were calculated for LES and all quality of life measures at comparable times: those not reported failed to approach significance.

**Table 16: Significant correlations of Life Events with other measures at four repeated-measures.**

LES 1	correlates with	SWL 1	(Pearson's $r=.18$ ; $p=.039$ )
LES 2	correlates with	L-W 2	( $r= -.18^*$ ; $p=.04$ )
		ABS 2	( $r=.23$ ; $p=.008$ )
		MS 2	( $r=.19$ ; $p=.026$ )
LES 3	correlates with	L-W 3	( $r= -.21^*$ ; $p=.015$ )
		ABS 3	( $r=.18$ ; $p=.039$ )
		MS 3	( $r=.31$ ; $p=.000$ )
LES 4	correlates with	MS 4	( $r=.18$ ; $p=.043$ )

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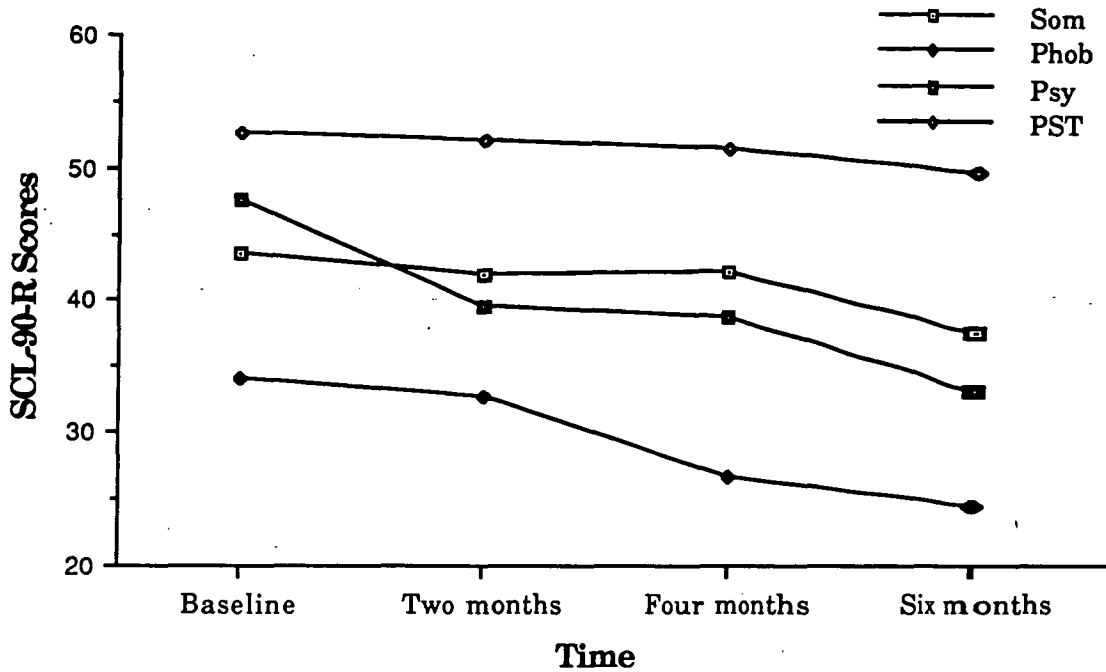
**\* L-W decreasing scores indicate improvement.**



### 7.4.5 Psychiatric Symptoms

For the whole sample, four of the twelve subscales the SCL-90-R yields showed improving trends which were significant. These were the subscales measuring somatization (Som), or distress arising from perceptions of bodily dysfunction ( $p=.044$ ); phobic anxiety (Phob), or persistent fear response which is irrational and disproportionate to the situation or whatever is feared ( $p=.006$ ); psychoticism (Psy), or symptoms often associated with psychotic illness ( $p<.000$ ); and the global measure of positive symptom total (PST), defined as the number of things subjects identified as distressing them ( $p=.005$ ). All of the trends were in the predicted direction (Figure 2).

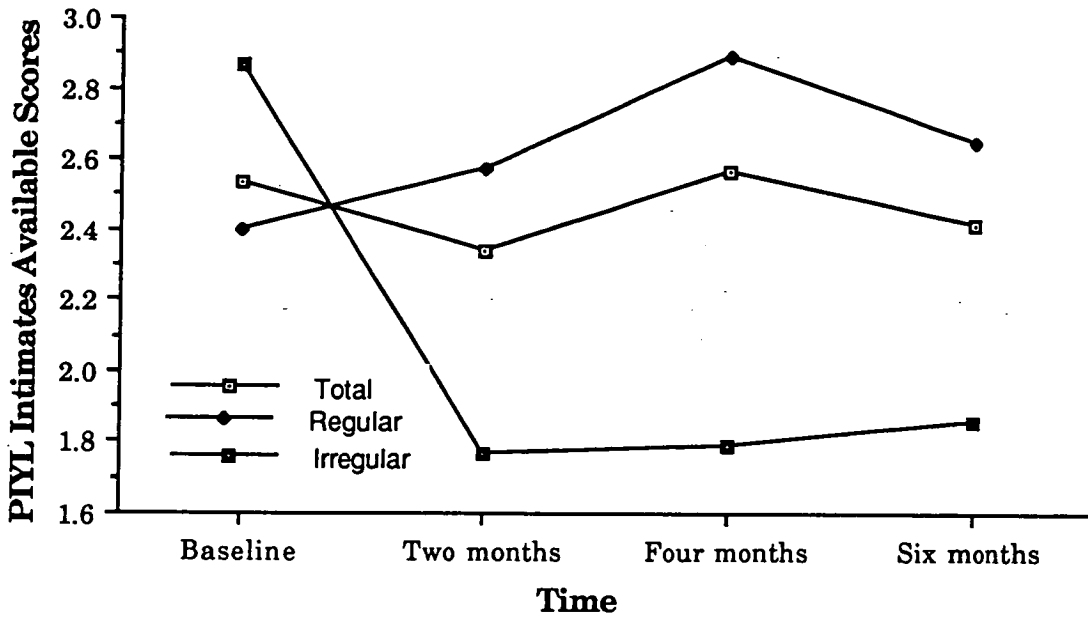
There was no significant difference between regular and irregular GROW attenders on SCL-90-R scores, and paired t-tests showed no significant difference between repeated measure four and the follow-up measure.



**Figure 2: Symptom Check List mean scores for four sub-tests across time.**

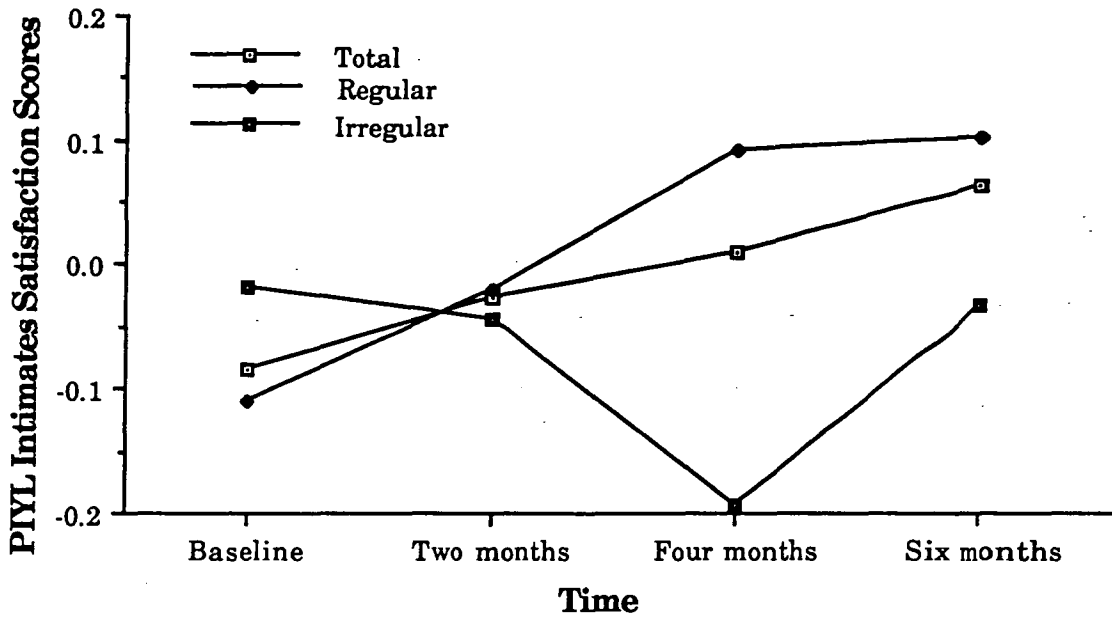
#### 7.4.6 Social Support

Over the four repeated measures, a MANOVA analysis of the PIYL measure showed no significant trend in the number of intimate friends available to subjects, though this was due to the influence of the irregular attenders on the trend ( $p=.043$ ), with the regular attenders having significantly more intimates available ( $p=.05$ ) (Figure 3a). There was also a significant difference between the sexes on this measure, ( $p=.011$ ) women reporting more intimate friends. The absence of a significant trend, however, was true of both sexes.



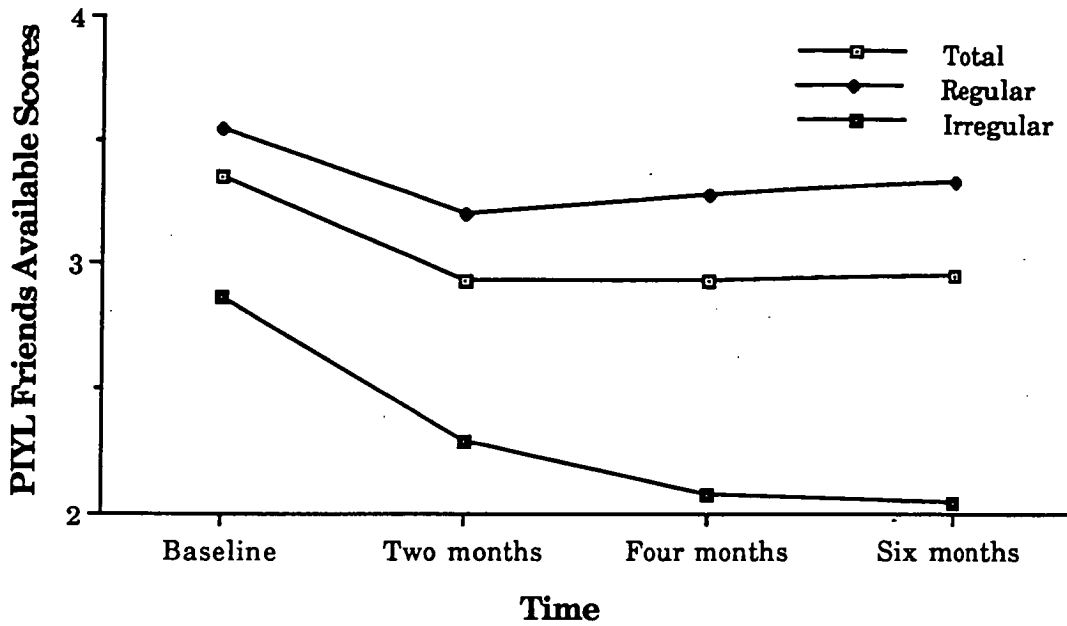
**Figure 3a** People In Your Life mean scores for intimate friends available across time, for total sample, regular and irregular GROW attenders.

Satisfaction with intimate friendships did significantly improve over the four repeated measures ( $p=.022$ ), the regular attenders contributing most to the whole group's trend ( $p=.035$ ) and having a trend when measured without the irregular attenders of a significance of  $p<.000$  (Figure 3b). The subjects also showed a significant improvement ( $p=.001$ ) by a paired two-tail t-test of satisfaction with intimate friendships between the last of the repeated measures and the follow-up measure at least six months later.



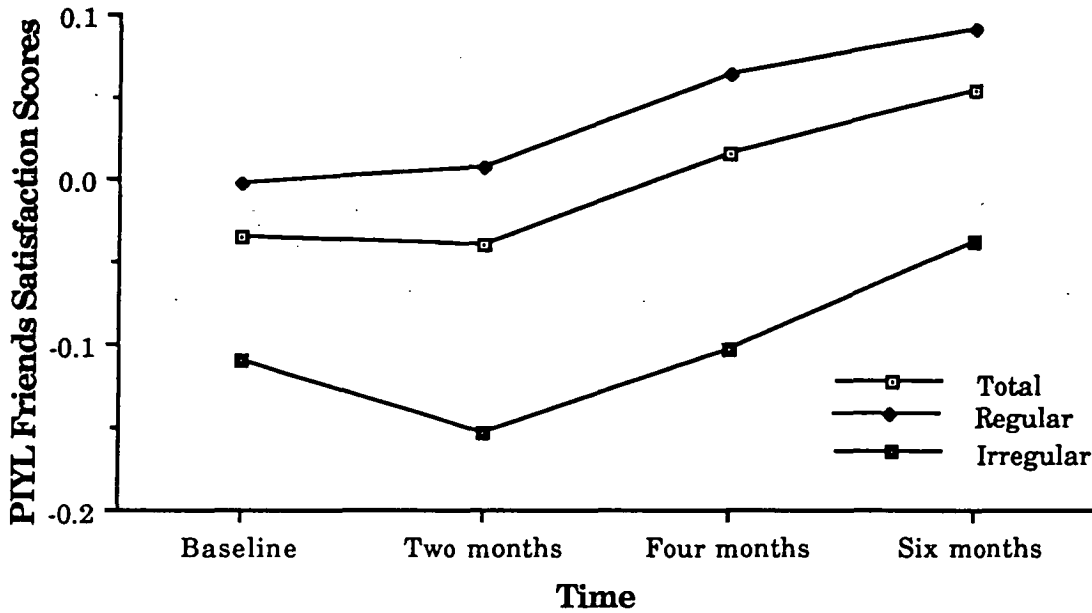
**Figure 3b: People In Your Life mean scores for satisfaction with intimate friendship across time, for total sample, regular and irregular GROW attenders.**

Analysis of the availability of less intimate friends and acquaintances showed a significant decrease in the number available to the subject group as a whole ( $p=.035$ ). There was, however, a significant ( $p=.001$ ) difference between the regular and irregular attenders, the regular attenders having more friends available (Figure 4a).



**Figure 4a: People In Your Life mean scores for friends available across time, for total sample, regular and irregular GROW attenders.**

Satisfaction with less intimate friendships showed a significant improving trend over time ( $p=.01$ ), the regular attenders again significantly better than the irregulars ( $p=.025$ ), (Figure 4b). A paired t-test between the last repeated measure and follow-up also showed significant improvement ( $p=.0001$ ).



**Figure 4b: People In Your Life mean scores for satisfaction with friendships across time, for total sample, regular and irregular GROW attendees.**

#### 7.4.7 Quality of Life

The five measures conceptualised as quality of life measures was each scored and analysed separately but the results were tested by Pearson's correlation algorithm and all but one were found to correlate significantly with each other at all times of measurement, including follow-up (Tables 17a to 17e).

**Table 17a: Correlations of quality of life measures at first measure (Pearson's r).**

---

	SWL1	ABS1	SLDS1	MS1
L-W1	-.421	-.511	-.579	-.256 *
SWL1		.359	.507	.178 **
ABS1			.479	.255 *
SLDS1				.309 *

---

**Table 17b: Correlations of quality of life measures at second measure (Pearson's r).**

---

	SWL2	ABS2	SLDS2	MS2
L-W2	-.437	-.515	-.479	-.374
SWL2		.548	.603	.418
ABS2			.491	.492
SLDS2				.489

---

**Table 17c: Correlations of quality of life measures at third measure (Pearson's r).**

---

	SWL3	ABS3	SLDS3	MS3
L-W3	-.703	-.503	-.630	-.524
SWL3		.587	.665	.420
ABS3			.526	.469
SLDS3				.420

---

**Table 17d: Correlations of quality of life measures at fourth measure (Pearson's r).**

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	SWL4	ABS4	SLDS4	MS4
L-W4	-.699	-.526	-.650	-.296 *
SWL4		.545	.678	.356
ABS4			.455	.472
SLDS4				.344

---

**Table 17e: Correlations of quality of life measures at follow-up measure (Pearson's r).**

---

	SWL5	ABS5	SLDS5	MS5
L-W5	-.600	-.492	-.574	-.357
SWL5		.602	.623	.288 *
ABS5			.529	.302 *
SLDS5				.310 *

---

\* $p < .01$

\*\* n.s.

All other p values  $< .001$

Changes between the final of the four repeated measures and the follow-up measure tested by paired two-tail t-test showed no statistical significance. It is noted, however, that changes on all five measures were in the predicted direction (Table 18).

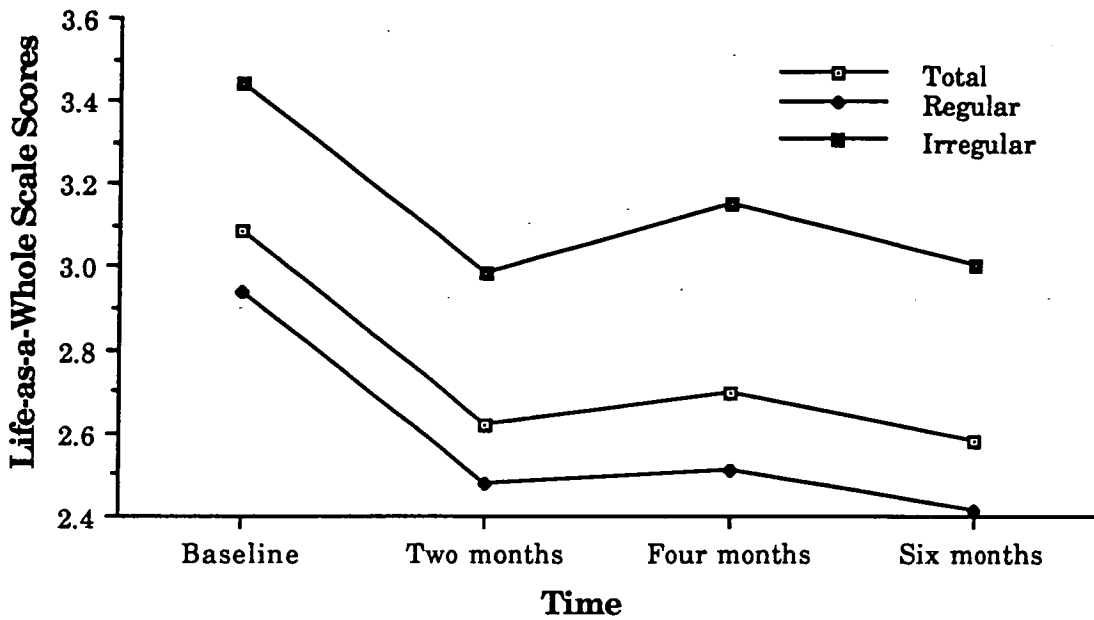


**Table 18: Means (Standard Deviations) of quality of life measures at Measure 4 and at follow-up.**

	L-W	ABS	SWL	FS	MS
Fourth Measure	2.46 (1.11)	1.04 (1.99)	21.81 ( 6.81)	51.35 (11.63)	21.62 (12.59)
Follow-up Measure	2.38 (1.13)	1.17 (1.19)	22.96 ( 6.70)	52.07 (12.59)	21.66 (12.77)

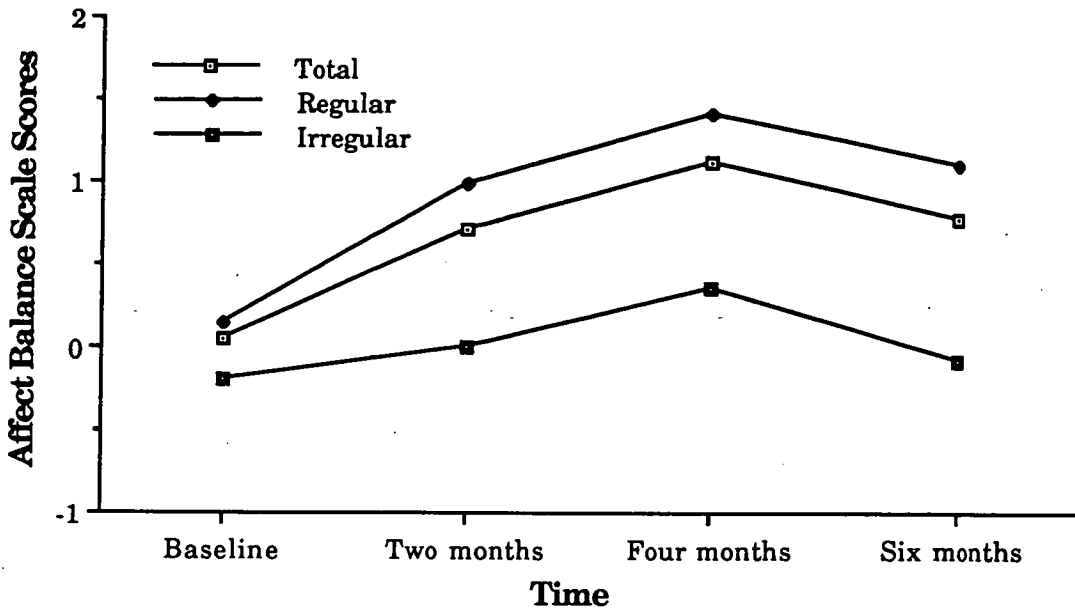
Considered separately, the quality of life measures, subjected to analysis by multivariate analysis of variance (MANOVA algorithm of SPSS-X) all showed significant improving trends over the four repeated measurements.

1. Life-as-a-Whole: The improving trend had a probability of .003 and there was a significant difference between the regular and irregular attenders ( $p=.003$ ) (Figure 5a: note higher scores indicate poorer perceived quality of life).



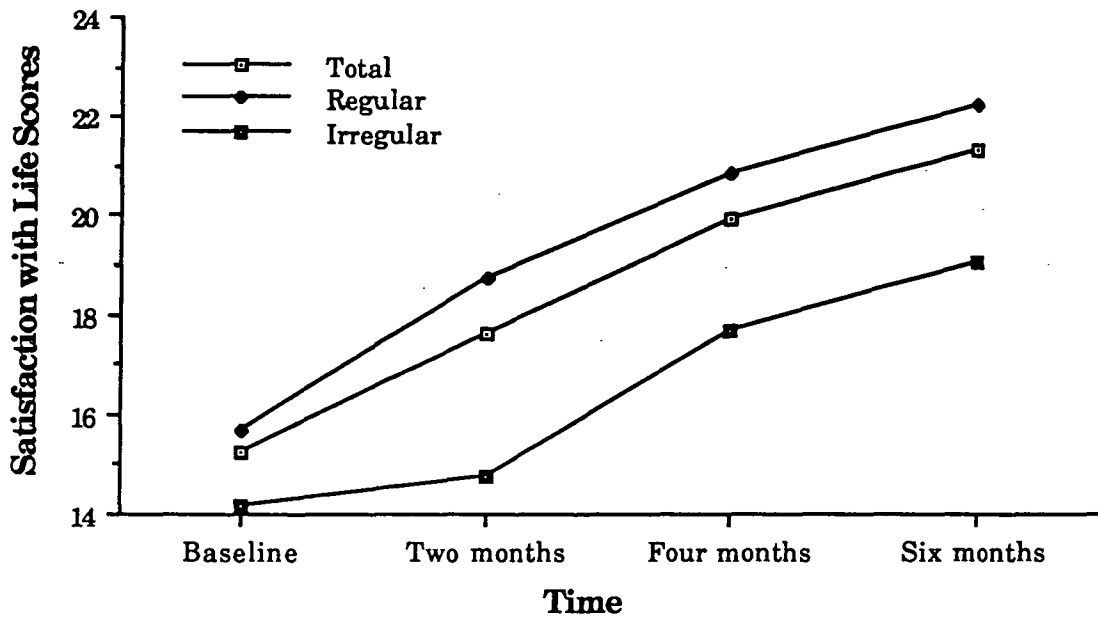
**Figure 5a: Life-as-a-Whole mean scores across time for total sample, regular and irregular attenders.**

2. Affect Balance Scale: Improving trend ( $p < .001$ ) and a significantly ( $p = .017$ ) higher score by regular attenders compared with irregular attenders was indicated (Figure 5b). Those who had been in GROW for more than a year scored significantly better than those who had been GROW members for less than a year ( $p = .026$ ).



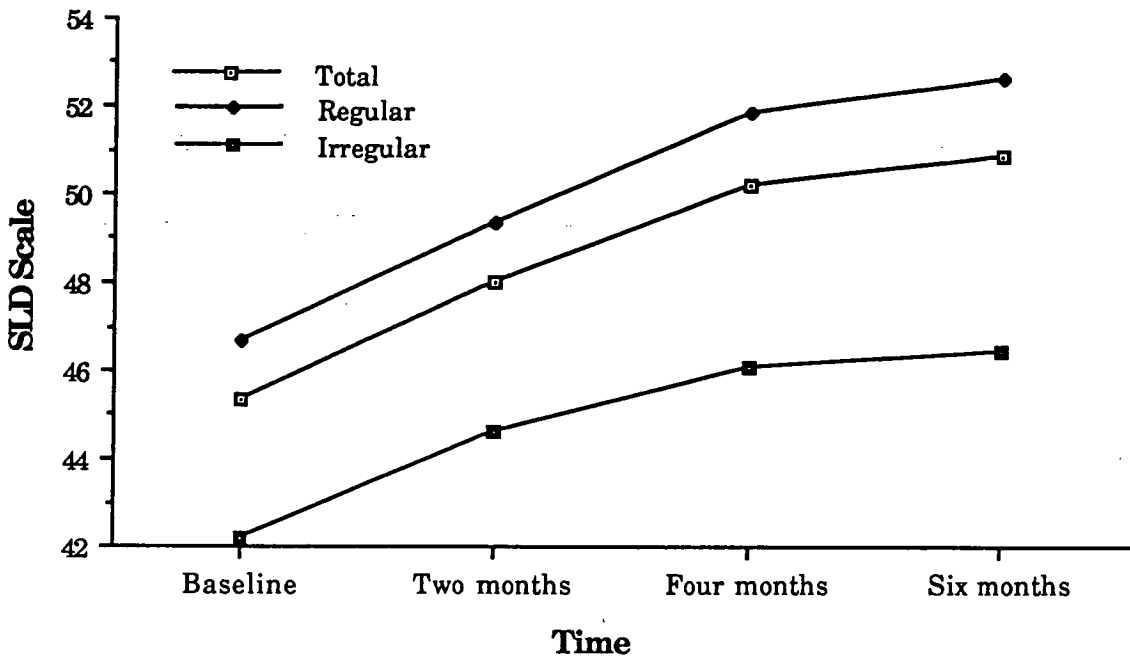
**Figure 5b: Affect Balance Scale mean scores across time, for total sample, regular and irregular attenders.**

3. Satisfaction With Life: An improving trend ( $p < .001$ ) was indicated and a significant ( $p = .024$ ) advantage of regular attenders over irregular attenders (Figure 5c). Longer-term GROW members also scored better than those in GROW for less than a year ( $p = .008$ ).



**Figure 5c: Satisfaction with Life mean scores across time for total sample, regular and irregular attenders.**

4. Satisfaction with Life Domains Scale: Regular attenders showed a significant ( $p=.026$ ) advantage over irregular attenders and the whole group showed an improving trend ( $p<.001$ ) (Figure 5d).



**Figure 5d: Satisfaction with Life Domains mean scores across time for total sample, regular and irregular attenders.**

5. Mastery Scale: Again, the whole group showed an improving trend ( $p < .001$ ) and the regular attenders better ( $p = .05$ ) than the irregular attenders (Figure 5e). If the sample was divided into groups that scored high on the Mastery Scale ( $n = 68$ ) and low on the Mastery Scale ( $n = 22$ ), the high MS group scored significantly better than the low MS group on three of the other four quality of life measures and also on the two subscales of the social support measure (PIYL) which related to availability of (FAV) and satisfaction with (FSAT) less intimate friends (Table 19).

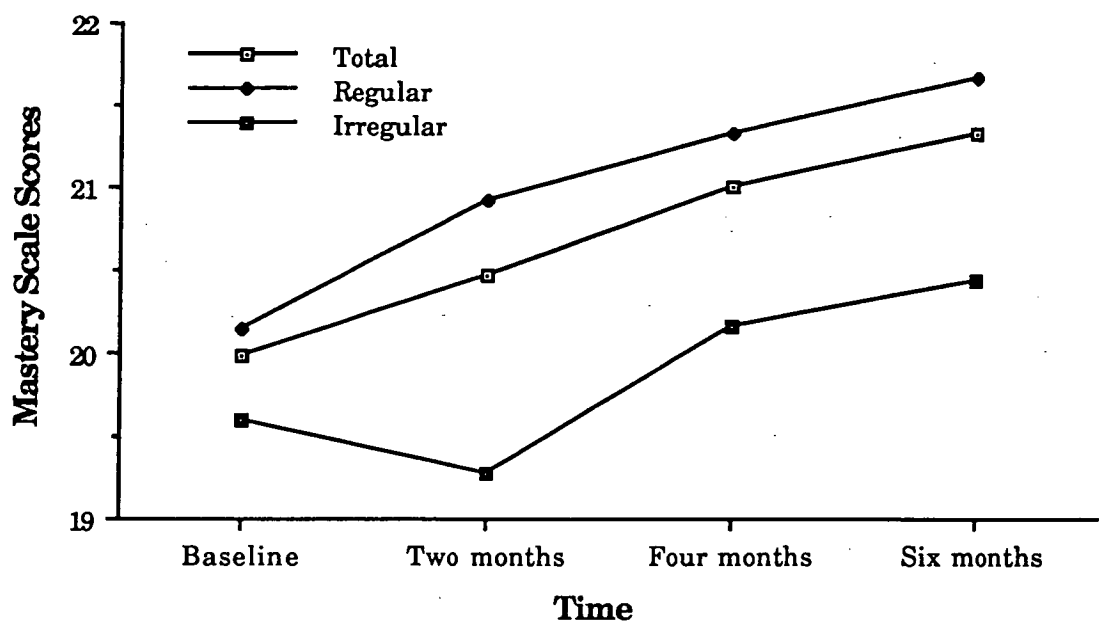


Figure 5e: Mastery scale mean scores across time for total sample, regular and irregular attenders.

Table 19: Differences between members scoring high (n=65) and low (n=22) on the Mastery Scale (MS).

Measures						
L-W	ABS	SWL	FS	FAV	FSAT	

Signif. of diff.**						
Between Hi and Lo	p=.04	p<.001*	n.s.	p=.026*	p=.009	p=.034
Mastery Scale						
Groups						

\*difference has effect on trend.  
\*\*Hi scores on MS = Hi scores on other scales

## 7.5 Control Group

After the initial interview with the sample, a non-equivalent control sample was recruited from among people contacting welfare agencies in Melbourne. Most were people who were making enquiries about adult literacy and numeracy, though some others were enquiring about welfare assistance. In the interests of confidentiality, no record was kept of the exact source of recruitment.

Summary informal descriptions were made of all subjects in the Phase 3 investigation e.g. "Female, 55, married, two grown children, lives with husband and one child, self-employed running small shop; depressed, lonely, impoverished marriage." "Male, 36, single, artist/poet, lives alone; schizophrenic on major tranquillizers." (Further examples in Appendix C.) On the basis of these descriptions, controls were recruited to match, as closely as possible, one of the descriptions of a GROW member.

### 7.5.1 Measures

The same measures were used as for the sample; there was no follow-up measure of the control group. The interview schedule was changed so that the list of problems GROW members had checked as being their reason for joining GROW read: "Have you ever sought help from any source for problems of [checklist of problems]?" Other questions relating to GROW were omitted.

### 7.5.2 Method

Recruiting and data collection was undertaken by a research assistant who was working part time in an agency concerned with adult literacy and numeracy. He was trained in the administration of the interview by the author, who continued to supervise the data collection. The research assistant explained the project to people, (who seemed to fit the thrust of one of the summary descriptions), with whom he came into contact for other purposes. If they agreed to take part in the four interview series, they were recruited as control subjects. Anyone who had had any contact with GROW was excluded.

Control subjects were not paid for their participation. The research assistant was employed for the purpose by a University of Tasmania Research Grant.

Forty control subjects were enlisted and 37 (92.4%) completed the four-interview repeated measure series which were available for analysis.

The controls were compared with all GROW subjects on demographic dimensions and the only significant difference was that the controls were younger ( $\chi^2=12.409$ ;  $p=.015$ ). Fewer of the controls had sought professional help at some time ( $\chi^2=4.636$ ;  $p=.037$ ), fewer had ever been hospitalised for stress, nervous or mental problems ( $\chi^2=16.294$ ;  $p<.001$ ) or taken medication for such problems ( $\chi^2=13.52$ ;  $p<.001$ ).



The problems for which the controls had sought some help which differ significantly from the whole sample are shown in Table 20.

**Table 20: Comparison of reported problems of controls (n=37) and subjects (n=101).**

	Chi-square	Probability
Fewer controls sought help for:		
loneliness	17.678	<.001
uncontrolled feelings	15.437	<.001
guilt	6.273	.012
anxiety	6.138	.013
low self-esteem	9.478	.002
More controls sought help for:		
family problems	6.5	.011
physical illness	8.366	.004
unemployment or financial problems	8.106	.004
bereavement	7.383	.007

The control group was matched with the subjects from the GROW phase 3 subjects referred to in the summary descriptions which had been the basis of the controls' selection. This procedure eliminated the demographic difference, but significant differences still distinguished the groups in all problems noted above except physical illness, bereavement and anxiety.

### 7.5.3 Control Group Results

Two multivariate analyses of variance were undertaken. The first analysed changes over the four repeated measures and the second compared changes of the controls and the matched- subject group (i.e. the subjects whose descriptions had been the basis of the controls' recruitment).

**Psychiatric Symptoms:** The control group showed an improving trend on five subscales of the SCL-90-R. These included three of those on which the GROW members showed improvement, (phobic anxiety,  $p=.025$ ; psychoticism,  $p=.021$ ; and the positive symptom total,  $p=.018$ ), and also anxiety (Anx) or signs and symptoms which are clinically associated with high levels of manifest anxiety ( $p=.024$ ); and the global severity index (GSI), a measure which combines the number of, and reported distress arising from symptoms and is claimed (Derogatis, 1983, p.11) to be the "best single indicator of the current level or depth of disorder" ( $p=.047$ ).

The matched-subject group and controls together showed significant improving trends on only two subscales: psychoticism ( $p=.006$ ) and the positive symptom total ( $p=.019$ ). In this respect there was no significant difference between the matched-subject group and the controls.

**Social Support:** Controls as a group showed significant improvement over time in the number of ( $p=.004$ ) and satisfaction with

( $p=.015$ ) intimate relationships but no change in less intimate friendships.

The matched-subject group and controls together showed significant positive trends on the measures of number of intimate friends available ( $p=.014$ ) and satisfaction with both intimate ( $p=.004$ ) and less intimate ( $p=.05$ ) friendships, and on each of these dimensions the controls were significantly better ( $p<.004$ ) than the subjects.

Quality of Life: Considered by themselves, the controls showed no significant trend on any of the quality of life measures over time.

Matched-subject and control groups together showed significant improvement on the Satisfaction With Life scale ( $p=.05$ ), the Satisfaction with Life Domains Scale ( $p=.003$ ), and the Mastery Scale.

The matched-subject group had a significant effect on the trend shown in the Satisfaction With Life scale, ( $p<.001$ ), but the two subgroups contributed to the other trends in a similar way and no significant differences were detected between the subgroups. There were no significant changes over time on the Life-as-a-Whole or on the Affect Balance Scale.

## 7.6 Discussion

Differences between the subject sample selected in this study and the population of GROW throughout Australia in marital status and educational status, while they were found to be marginally significant in the typology established in Phase 2, had otherwise not been found to be related to other results at any phase of this investigation. However, they must be acknowledged in generalising from the results of this phase.

Clearest changes most consistently reported occurred on the group of scales conceptualised as relating to quality of life. On each of these measures the trend to improvement was highly significant. Furthermore there was a consistent and significant difference between regular and irregular attenders, the regular attenders always being those with the better scores: those who attended GROW regularly for at least one two-month period had a more positive balance of experiences eliciting positive versus negative feelings, (ABS); rated their lives as closer to their ideal, (SWL); had a more positive view of their own control over the circumstances and events in their lives, (MS); and expressed more satisfaction with various domains of their lives (SLDS) and life as a whole (L-W).

Caution is warranted in interpreting these differences between the scores of regular and irregular attenders as three major factors may confound the measures. First, the subjects are self-selected into the

sub-groups and there is no control of the multiple variables which influence this selection (Cook & Campbell, 1979); secondly, inherent differences in the sub-groups are unknown; and, thirdly, the baseline measures are consistently higher for the regular attenders and incremental improvement, though also consistent, does not reach statistical significance.

Correlations of scores on the Life Events Schedule and some of the quality of life measures, at corresponding times, enhances estimates of validity of the measures. The suggestion that changes in quality of life is merely a reflection of an improved balance of life events is countered by the finding that there is no trend in LES scores to parallel the trend in quality of life measure scores.

The significant differences between long term (>1 year) GROW members and those who had been members for shorter time refer to the two quality of life measures which conceptually are the two which most closely tap mood states (SWL and ABS). The differences are not paralleled by differences in social support measures, raising the possibility that they are more closely associated with members' involvement with the GROW programme rather than the social network which GROW provides. The GROW programme's cognitive emphasis may encourage members to experience (or at least recall) more positive feelings than negative feelings and may enhance their perception of their lives as closer to their ideals, perhaps by modifying their aspirations. Changes of this kind might be expected to be

gradual, and, if they were related to exposure to GROW's ideology, to be measurable only after long term membership.

The Mastery Scale is conceptualised as a measure of the degree to which subjects consider themselves to be in control of their own lives and to be contributors to the communities of which they are part. Regular attendance at the meetings of GROW over time appears to coincide with an enhancement of members' perception of control. For those members for whom this perception is stronger (high MS scores) scores on three of the four other quality of life scales are elevated: those which relate to satisfaction with various definable domains of life, (SLDS), life as a whole, (L-W) and balance of negative and positive feelings (ABS). It may be that this sense of greater control translates into a confidence which allows them to interact more freely (enhanced FAV) and more satisfyingly (FSAT).

It may be concluded that for the subjects of this study attendance at GROW meetings was coincident with an improved perceived quality of life and an enhanced satisfaction with relationships. Further, the level of satisfaction reported was higher for those members who attended regularly compared with irregular attenders. This would appear to be a function of more than the social support attendance provides and may be a more or less direct effect of the programme and its processes.

The trends apparent over the repeated measures are not reflected in significant changes, as measured by paired t-test, between the fourth measurement and the follow-up measure at least six months later,

except for appreciation of friendships, both intimate and less intimate. Differences on all measures are, however in the predicted direction.

When the Phase 3 study was begun subjects reported the length of time they had been associated with GROW on a scale of one to five: 1 = <1 month; 2 = 1-3 months; 3 = 3 months - 1 year; 4 = 1-2 years; 5 = >2 years. The sample mean was 2.1: an average of about three months. By the time of the follow-up measure the minimum time from first joining GROW could have been no less than a year and the average between 15 months and two years. Data does not allow a more precise analysis, but it would seem likely that for most GROW members, if changes in perceived quality of life were to result from participation, such changes would be most marked in the first months of membership and subsequently be less marked or plateau. Reported results would be consistent with this prediction.

The pattern of differences between the control group and subjects diminish the power of inference from the changes measured. Demographic differences, largely eliminated by matching the control group with the subjects whose description was the basis of their selection, made little change, however, to the differences in kind of problems the controls reported compared with the subjects' problems. This suggests that the controls (and the matched-subjects) were essentially less lonely (isolated), less troubled by the "internal" dimensions of their problems (e.g. uncontrolled feelings, guilt, anxiety) and more concerned with the "external" dimensions (e.g. financial

problems, physical illness, bereavement) than the subject group as a whole.

The fact that improvements on a number of measures were less significant for the control group and the matched-subject group together than for the whole subject group suggests that any efficacy which GROW may display is less pronounced with changing perceptions of the "external" type of problems than changing perceptions of psychological well-being. It also suggests that GROW is less effective with those who perceive themselves not to be lonely (controls and matched-subjects) than with those for whom loneliness is a problem.

The inference that persons with a problem pattern similar to those of the control group should be discouraged from GROW membership is to be resisted: GROW's processes as disclosed in the Phase 2 study, are highly interactional and it may be that any effectiveness which it displays is in part dependent on the membership of younger members with a more "external" problem such as those of the control group and matched-subjects.

This suggestion is supported by the finding that the most consistent improvement over the four repeated measures and the follow-up measure was in the satisfaction subjects expressed with their friendships, both intimate and less intimate. This increased satisfaction was not paralleled by an increase in the number of friends,



intimate and less intimate, who were available. In brief, it may be said that GROW members did not increase the number of their friends, but did increase their appreciation of the friendships they had.

The reported improvement on the measure of psychiatric symptoms is the change least clearly linked to participation in GROW. Not only were the changes of a similar kind reported by the control group, but there were no significant differences between the regular and irregular GROW attenders. Nonetheless, improvements, (and no significant deteriorations) were reported, most consistently on the global subscale which reports the total number of symptoms which caused distress. It may be that involvement in any kind of programme may be effective in achieving improvements of this kind. (Although there was no record of whether control subjects were involved in any group or programme at all, the fact that they were recruited while in touch with a welfare or educational agency makes the assumption likely).

Evidence of a causal link between GROW membership or attendance and changes measured is far from conclusive. In part this inconclusiveness is due to limitations inherent in a community organisation, membership and processes of which cannot be controlled, and in part to an incompletely matched nonequivalent control group.

It may also be that changes measured are due wholly or in part to the author's intervention and the nature of this investigation would appear to make it particularly vulnerable to criticisms of reactivity. In the first place subjects' status as volunteers makes them more likely to

have been influenced by demand characteristics (Orne, 1962; Rosenthal & Rosnow, 1975) and the author's identification as an acquaintance (through his prior association with GROW), enhanced by continuing contact through the 12 months of the investigation, (Rosenthal, 1966), may have had a substantial effect on results. In addition other postulated sources of demand characteristics include the experimenter's sex, scientific experience, personality, expectations and his modelling behaviour (Rosenthal & Rosnow, 1975): any or all of these may have had a bearing on the results reported.

Three factors argue against this suggestion.

First, contact with the individual subjects was limited to five interviews, each of about an hour and a half, four spaced at two month intervals, the fifth at least six months later. It seems unlikely that such minimal contact could make consistent and measureable changes in perceived quality of life.

Secondly, the large number of variables in the measures used, (a total of 176 at each interview), made deliberate production of socially-acceptable responses in a consistent pattern of improvement virtually impossible.

Thirdly, all the subjects, regular and irregular attenders, were seen by the author on the same basis and, while it did not reach statistical significance, there was a consistently greater improvement over all the repeated measures by the regular GROW attenders than by the

irregular attenders. In the unlikely event that all the shared improvement by regular and irregular attenders was measurement-effect, the consistent difference between the two groups may have been due to the difference in their attendance at GROW.

## **CHAPTER 8**

### **CONCLUSIONS**

## 8.1 Summary

Phase 1 of this investigation delineated an organisation in the programme of which about 1800 people were involved Australia-wide in a particular week. Subsequent analysis of meeting attendance patterns suggested that in a year more than 7500 individuals attend at least one meeting and that between 2000 and 2500 of these would attend only one meeting. From these figures it would seem a reasonable estimate that GROW in Australia has some significant contact with at least 5000 individuals in a year.

Characteristics of the population of GROW do not differ significantly from state to state within Australia. Membership was found to be about two-thirds female and predominantly between 30 and 60 years of age. About two-thirds are on the third and fourth ranks of a five-point employment status scale.

In terms of psychiatric symptoms, they rate between psychiatric patient and normal groups, and up to 96% of members had at some time sought professional help for stress, nervous, or mental problems.

GROW members perceive themselves to have less adequate social support than non-GROW members, and for those among GROW members who are more disturbed, this difference is accentuated.

Two major groups of GROW members can be distinguished: those whose primary reasons for first going to GROW, as they reported it, would be met by change in some aspects of their behaviour; and those who had an experience of disrupted relationships and whose priorities would appear to be to enlarge or enhance their social support network. GROW purports to provide for both these needs, and may do so, though it is observed that sometimes these objectives may conflict. On the other hand, the supportive network which GROW provides may often provide a necessary context in which behavioural changes can be encouraged.

GROW provides a supportive and secure climate in which encouragement predominates over criticism or confrontation. However, GROW, compared with some other mutual help groups, is more ready to use "hard" processes of giving feedback and confrontation in the interests of producing change in members' lives.

The interaction at GROW meetings is controlled by a highly structured format which members perceive as relatively resistant to change but which, they consider, provides the opportunity for strongly supportive relationships.

The network of supportive friends which GROW provides is rated by GROW members as more satisfying than other friendships. Furthermore, appreciation of friendships, as distinct from an increased number of friends, is consistently correlated with length of association with GROW. Data from both Phases 2 and 3 of the study strongly supported this conclusion.

Membership in GROW has been found consistently to be coincident with a significant decreased use of professional services and medication for psychological or psychiatric disorders. At the same time, no deterioration (and in some dimensions an improvement) in psychiatric symptom measures suggests that such decreased use of professional services and/or medication might be expected. Despite criticism of some medical intervention, (e.g. GROW 1983, pp.20-21), GROW officially encourages co-operation of its members with professional help, and there is no evidence that GROW inappropriately discourages its members from the use of professional services or prescribed medication.

A sample of GROW members, followed for a period of six months, perceived their lives as having improved in a number of ways. They felt better about their lives as a whole as well as specific domains of their lives, they considered their lives more satisfactory by their own standards, on the balance their affective mood was better, and they felt they had more control within their lives. They were also more satisfied with their friendships and more intimate relationships, and were distressed by fewer psychiatric symptoms. This was true for all members of the sample, but for those who reported at least two months' regular attendance at GROW meetings, compared with less regular attenders, the improvements were enhanced.

At least six months later again, they reported improvement on these dimensions which, though it did not reach statistical significance

except in satisfaction they reported with their relationships, was consistent across all measures.

A non-equivalent control group did not show the same improvement as the GROW members over six months. However, the lack of match between the sample and the GROW members as a whole removed much of the relevance of this comparison. A subsample of GROW members, more closely matched to the controls did not show the same consistent improvement as the whole sample, suggesting that GROW was of more use to some than others of its membership. Generally it was the younger members, whose presenting problems concerned more concrete matters who seemed to be less well served by GROW, though their presence may make an important contribution to the effectiveness of the group.

Overall, the results of this study supports the conclusion that GROW provides, for a large number of people who have problems of psychological distress or disorder, a relief of dependence on professional help or medication and an improved sense of well-being. It is probable that it achieves this through providing a structured programme based on an articulated ideology, pointing to appropriate behavioural and attitudinal changes, and a supportive environment in which behaviour changes are encouraged.



## 8.2 Discussion

Attempts to examine GROW's processes analytically to assess relative effectiveness of components inevitably loses something of the total effect becoming part of the organisation may have. As Suler (1984) observed of mutual help groups generally, the transition to GROW's philosophy resembles a religious conversion for many members. GROW uses the term "Committed Grower" (GROW, 1983, p.77) to describe members who, having attended at least three meetings, are prepared to make a statement at the beginning of each meeting that they undertake to use GROW's programme and exercise leadership in accordance with GROW's programme and methods. The meaning of "committed" in this context is a clear reference to a moral commitment to GROW's ideology, as distinct from the promises, (in the other part of the "GROW Commitment" recited at each meeting), to respect confidentiality, to speak the truth and not to lead or aid other members in "serious wrong" (p.77).

Understanding of changes in GROW members' social support, psychological or psychiatric symptoms, use of other mental health resources, or perceived quality of life, then, may be enhanced if these dimensions are seen within the context of a committed attachment to the organisation. GROW's philosophy provides for its members the motivation to change, the cohesion of its fellowship provides support and demands from its members the provision of support for others, its call to leadership (in varying degree) to all members provides a vested

interest in the organisation's maintenance, and the prospect of contributing to its recorded reservoir of experience through the established mechanism of leadership meetings provides an investment in its future prosperity.

Reviewing theoretical implications of the interrelation of social support measures, Sarason, Shearin, Pierce and Sarason (1987) concluded that "a supportive relationship involves the communication of acceptance and love" and that the main effect of these communicated feelings is "to foster in supported individuals the feeling that they are worthwhile, capable, valued members of a group of individuals and that the resources necessary for the pursuit and achievement of their goals are available to them" (p.830).

The finding of this investigation is that GROW members' perception of the quality of their social support, (the successful "communication of acceptance and love"), improves over time. Understood in the context of their adoption of GROW's ideology, it may be that they appreciate in this support the means to advance toward the achievement of their personal goals. This advance, GROW's teaching is, is not chiefly through the use of medication or through reliance on professional help but through using resources available to them in the GROW group. Hence the decreased use of medication and professional help that all three phases of the investigation have indicated.

Group resources on which members call to achieve change in their lives appear to be cognitive and behavioural, drawing on processes with recognisable similarity to the techniques employed within the cognitive-behavioural movement of psychotherapy. For example, members encourage each other to reframe their self-instruction, challenge each other to shape their behaviour to desired goals, monitor for each other the performance of practical tasks, and model for each other appropriate interactions.

The mutuality of these processes would seem to be central. The challenge to accept some leadership role frequently coincides with a member's first commitment to GROW's ideology after attendance at three weekly meetings. From then on, without any more formal initiation, members may expect to be invited to chair the meetings and are invited to take part in leadership meetings at which written programme content may be produced. This practical working out of Reissman's helper-therapy principle (Reissman, 1965; 1990) might be expected to have the double effect of assisting personal change and welding members more strongly, by virtue of the responsibilities they assume, to the ideological commitment they have undertaken. As Reissman puts it, "the problem becomes part of the solution" (1990, p.225).

Furthermore, again to quote Reissman, "Helping oneself can be as empowering as helping others" (1990, p.224). Involvement in this mutual process may give members a sense of their own usefulness,

thus enhancing their self-esteem, their subjective quality of life and their sense of control in the events of their own lives and in the community.

A fundamental respect in which participation in GROW differs from professional or professionally-organised psychotherapeutic interventions is in the commitment to GROW's ideology mentioned above. Levine points out the difference between "visiting" a setting for treatment and "belonging" to a mutual help group (1988, p.178). This means that becoming a GROW member, provided membership is "practiced" long enough for the commitment to become established, is often the adoption of a different way of life predicated on a different set of values. Although this individual commitment is separate from continued attendance at group meetings, the fact that group meetings continue to be available (even if they are not regularly attended) may serve to keep members' commitment current. The report of one GROW member reflects opinions expressed frequently to the author: "Since I started going to GROW a few years ago, things seem different. I suppose I'm happier now. I don't go all that often -- probably not as often as I should -- but I guess I'll always be a GROWer" (female GROW member, aged 36; personal communication, Feb. 1989)

Comparison of GROW membership with psychotherapy, however, as Levy (1984) pointed out with regard to mutual help groups generally, is to overlook the systemic character of the organisation. GROW was founded as a response to a felt need of its first members, recently

discharged from mental hospital and without what they considered to be adequate support. As such it was part of a broader programme of mental health service delivery, not oriented to cure (not necessarily an appropriate goal: see Lamb, 1981; Jacobs & Goodman, 1989) so much as to creating what Rappaport (1988, p.3) called "an environmental niche" for its members. Viewed from the perspective of an alternative system of service delivery, GROW has advantages outlined by Rappaport (1988; Rappaport et al., 1985) of being on-going, being assertive through the links it establishes among members, and being flexible in the demands it makes.

These among other considerations need to be held in mind in planning future research. Some of the acknowledged limitations of the present study may have been avoided and careful replication is warranted. Other problems of research methodology have yet to be solved (Jacobs & Goodman, 1989), but it is suggested that evidence presented in this investigation is sufficient to warrant the expenditure of further effort.

The results of this investigation, at the least, suggest that GROW provides a substantial contribution to the system of mental health care in Australia. Perhaps, as has been suggested in the United States, (Jacobs & Goodman, 1989; Borkman, 1990), GROW along with other mutual help organisations, may achieve a pivotal role in the delivery of mental health services in the next decade. One of the principal forces shaping health services generally at this time is the escalating cost

involved; research into the cost-benefits of GROW, a start toward which has been undertaken in South Australia, (Burgess & Anstey, 1987), is warranted to establish whether mutual help groups provide sought-after efficiencies.

A second area of future research should involve an examination of GROW's organisational structure and the role and influence of the national organisation on the way in which the groups work. One might assume that mutual help organisations may be in the same danger as any organisation of falling victim to the old saw: "The idea gives birth to the organisation which kills the idea". That the systemic organisation has an influence on groups' stability has been established (Leventhal, Maton & Madara, 1988); the influence such systemic relationships have on the processes and their efficiency has yet to be investigated.

Finally, the intermeshing of mental health care provided by professionals and professional agencies, and that provided by GROW demands urgent investigation. Numbers of recently-published papers (e.g. Pancoast, Parker & Froland, 1983; Balgopal, Ephross & Vassil, 1986; Galanter, 1988; Yoak & Chesler, 1985; Lavoie, 1984; Toro et al., 1988; Jacobs & Goodman, 1989; Borkman, 1990) have examined varying dimensions of the relationship between mutual help groups and professionals, and each suggests ways in which better co-operation may be achieved. However relationships between GROW in Australia and professionals, with important exceptions, remain suspicious and

distant if not hostile, awaiting a clear description of the potential and limits of each mode of service delivery and guidance of passage between the two modes.

This is not to suggest a melding of the two forms of service delivery, nor any control of mutual help groups by outside agencies. Discussing the relationship of mutual help groups with formal health care systems, Borkman (1990) urged the importance of allowing groups "to succeed or fail without professional, governmental, or other outside interference" (p.329). GROW has certainly managed to avoid professional co-optation (Mowrer, 1984) and would claim to be "a source for changing professional practices" (Borkman, 1990, p.328) as part of its goal "to meet the demand...for a popular school of life and leadership for mental health" (GROW, 1983, p.1 and p.21). If the changes in members' lives which this investigation appears to indicate can be substantiated and attributed to their participation in GROW, such an ambition may not be misplaced.

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## **APPENDICES**

## **APPENDIX A**

**Questionnaire - Phase 1**

**Cover Letter - Phase 1**

**Research Participant Card**

**Significant difference of clusters as measured by  
chi-square in typology of GROW members based  
on reasons for joining GROW**

University of TasmaniaRESEARCH PROJECT

This questionnaire is an attempt to get a picture of who GROWers are, and every member of every GROW group in Australia is being requested to fill one out.

It's important that your answers are honest but don't think about or worry over the answers too much: just answer each "off the top of your head". It will be of great help if you try to give some answer to every question.

Your reply will be completely anonymous, identified only by the Research Number which you have been given. Just tick the boxes or write on the lines provided.

Research Number \_\_\_\_\_

Name of Group \_\_\_\_\_

Type of Group    General ☐

Special ☐

Sex:        Male ☐        Female ☐

Age in Years: \_\_\_\_\_

Marital Status:        Married ☐        Widowed ☐        Single ☐

Separated/Divorced ☐

Occupation \_\_\_\_\_

If pensioner or unemployed, previous occupation \_\_\_\_\_

If a dependant, breadwinner's occupation \_\_\_\_\_

Number of Dependants \_\_\_\_\_

Number of Children \_\_\_\_\_

Education:

- left school at 15 or younger ☐
- finished high school ☐
- attended a tertiary institution ☐
- qualified at tertiary institution ☐
- trade qualification ☐

Do you live:

- on your own ☐
- with your brothers/sisters/parents ☐
- with a spouse/partner/child or children ☐
- with friends ☐
- in a hostel ☐

How long have you been in the GROW group?

Less than 1 month ☐      Less than 3 months ☐      3 months - 1 year ☐  
 1 - 2 years ☐      More than 2 years ☐

Have you been in GROW before?    Yes ☐    No ☐

Where did you learn about your present group?

From a friend ☐      From a doctor or other professional ☐  
 From an advertisement or other publicity ☐      Other ☐

Did you know about GROW before?    Yes ☐    No ☐

Other than GROWers and members of your immediate family, would you say your network of friends numbers:

None ☐      Fewer than 5 ☐      5 - 15 ☐      More than 15 ☐

Do you know anyone with whom you could share your feelings about almost anything, good or bad, that happens to you?

Yes ☐    No ☐

Is any such person a member of your GROW group?    Yes ☐    No ☐

On the average, do you have contact with members of your GROW group other than during meetings?

Never ☐      Less than once a week ☐      At least once a week ☐  
 Every day ☐      More than once a day ☐

Do you belong to any church or religious group?    Yes ☐    No ☐

If yes, is your religion:

Christian ☐    - Roman Catholic ☐  
                              - Anglican ☐  
                              - Uniting Church ☐  
                              - Other ☐  
 Jewish ☐  
 Other Religion ☐

In the past year have you attended church services or religious ceremonies?

More than once a week ☐      Once a week ☐      Once a month ☐  
 Less than once a month ☐      Never ☐



In general, how religious-minded would you say you are?  
(Circle the statement closest to your view.)

Not religious at all	Less than most people	Average	More than most people	Very Religious

Why did you join GROW? (Tick as many as apply.)

- For help with - loneliness/isolation  
 an unhappy relationship  
 drinking or drug problems  
 family problems  
 physical illness  
 unemployment/financial problems  
 bereavement  
 misery/depression  
 recovery after hospitalization  
 uncontrolled feelings  
 guilt  
 anxiety/nervousness  
 fear of strange places/people  
 broken relationship  
 other \_\_\_\_\_


Has the opportunity of discussing the problems of others in your group  
changed the way you see your own problems? (Circle the statement closest  
to your view.)

A great deal	A good deal	Moderately	A little	Not at all

How would you rate the helpfulness of GROW with the problem that brought  
you to GROW? (Circle the statement closest to your view.)

Extremely helpful	Rather helpful	Didn't make much difference	Things got worse	Made things much worse

What did the group do to help you? (Tick as many as apply.)

Made me feel less lonely

☐

Helped me change my ways of acting

☐

Gave me something to do

☐

Helped me see others' points of view

☐

Taught me to control my feelings by thinking

☐

Helped me be less fearful

☐

Taught me I could help others

☐

Gave me a feeling of belonging

☐

Nothing

☐

Other \_\_\_\_\_

Have you sought help for your problems from helping professionals in the past?

Yes ☐

No ☐

How would you rate their helpfulness? (Circle the statement closest to your view.)

Made things  
much worse

Things got  
worse

Didn't make  
much difference

Rather  
helpful

Extremely  
helpful

--	--	--	--

Are you getting professional help now?

Yes ☐

No ☐

In the past have you gone to other sources, other than professionals, for help with the problems that brought you to GROW?

Yes ☐

No ☐

Have you ever had prescribed medication to help you with stress, nervous or mental problems?

Yes ☐

No ☐

Do you take any such medication now?

Yes ☐

No ☐

Has GROW lived up to your expectations so far?

(Circle the statement closest to your view.)

It has exceeded  
my best hopes

It's better than  
I'd expected

It's about  
what I thought

It's not as good  
as I'd hoped

I'm very  
disappointed

--	--	--	--



# The University of Tasmania

Postal Address: Box 252C, G.P.O, Hobart, Tasmania, Australia 7001

Telephone: 202101. Cables 'Tasuni' Telex: 58150 UNTAS

IN REPLY PLEASE QUOTE:

FILE NO. ....

IF TELEPHONING OR CALLING

ASK FOR

Dear Organisers and Recorders

Your co-operation is essential for the success of this phase of our research project. We do not want to give you a whole lot extra to do, but if you would undertake these few tasks with care, we would be much in your debt.

First, please give to each GROWer in your group:

- ONE of the identification cards enclosed, and
- ONE copy of the enclosed questionnaires.

Next, if there are any identification cards left over after each member of your group has one (including you!), just seal the remainder in the stamped addressed envelope in which they came, and pop them in the mail. (This way we will know how many GROWers have cards).

Please ask the GROWers to complete the questionnaires and return them to you within two weeks. When you get them back, put all the completed questionnaires in the large envelope, seal it, and mail it. (It may be possible for the GROWers to fill out the questionnaire at the meeting; it should take only a few minutes. And do not forget to do one yourself!). If there are any unused questionnaires left over, just throw them away.

Encourage everyone to answer all the questions somehow even if they are not too sure of the answers. Although the answers must be honest to be of any use, do not stew over them: just the answer that comes first to mind will be OK.

Finally, here are some of the questions you might be asked:

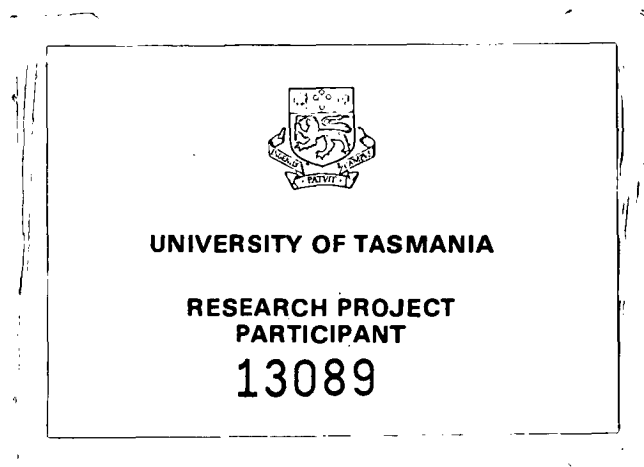
- Q: If a GROWer is absent from the meeting, can he or she have a copy of the questionnaire and a research number?
- A: Yes, by all means; so long as the questionnaires are all returned together within, say, two and a half weeks.
- Q: What does the question about occupation mean?
- A: We need to know the kind of work from which you might earn a living. If you have not ever worked, then the occupation of your father or mother (whoever earned the household's income) would be right.
- Q: Why have some questionnaires have a line across the corner?
- A: There are two ways in which the questionnaires are set out (though the questions are all the same) for technical reasons. The line makes it easy to distinguish them. Your group should be given about equal numbers of each type.
- Q: Can we look at each others' answers?
- A: It does not really matter, but do not pressure each other: it is up to the person who filled it in.

We hope this covers most of the problems you may strike. In any event, we are most grateful for your help and co-operation.

With every good wish,

JIM YOUNG and CHRIS WILLIAMS

**Research Participant Card as issued to subjects of this investigation.**



SIGNIFICANT DIFFERENCES OF CLUSTERS AS MEASURED BY CHI-SQUARE IN THE TYPOLOGY OF GROW MEMBERS  
BASED ON REASONS FOR JOINING GROW.

Variables	Cluster 1 'Symptoms'	Cluster 2 'Network'	Cluster 3 'Trauma'	Cluster 4 'Bereav't'	Cluster 5 'Helper'
Sex	19.0** >females	N/S	12.8** >males	N/S	6.67* >males
Age	N/S	7.61* > 30 yrs	13.9** < 30 yrs	15.12** > 60 yrs	N/S
Marstat	8.66* >married >widowed	6.99* >single/ >separated	33.9** >single	10.23* >widowed	N/S
Dependents	N/S	4.6* >none	N/S	N/S	N/S
Children	N/S	N/S	N/S	N/S	6.8** >none
Education	4.51* >./high school	N/S	N/S	N/S	18.23** >Graduates 12.92* >14/school
Live with	N/S	N/S	20.82** >parents or siblings	N/S	N/S
Grow Time	N/S	N/S	N/S	N/S	5.45**<1yr 19.41** < 1 mth
Grow Refer'l	N/S	N/S	9.04* >referred by profession'l	N/S	N/S
Friends	N/S	N/S	5.68** <5 friends	N/S	N/S

- ° p = <.05  
°° p = <.02  
\* p = <.01  
\*\* p = <.001

Variables	Cluster 1 'Symptoms'	Cluster 2 'Network'	Cluster 3 'Trauma'	Cluster 4 'Bereav't'	Cluster 5 'Helper'
Grow Sharer	N/S	N/S	N/S	N/S	15.57** <no
Religious Affiliation	N/S	N/S	N/S	4.01* <none	N/S
Think Religious	N/S	N/S	N/S	N/S	8.89* >more/ very
View Problem	N/S	N/S	N/S	4.35* >moderate/ not at all	N/S
Grow Helped	N/S	4.79* >extremely	4.40* >no diff./ not at all	N/S	N/S
Less Lonely	N/S	N/S	7.32* >more (less Cl.5)	N/S	93.88** >fewer
Change Act	N/S (less Cl.5)	N/S	N/S	27.17** >fewer	49.92** >fewer
Something To Do	N/S (less Cl.5)	12.23** >fewer (less Cl.5)	18.47** >more	N/S	29.44** >fewer
Change View	N/S	N/S	N/S	5.45** >fewer (less Cl.5)	55.04** >fewer
Control Feelings	5.47** >more (less Cl.5)	N/S	N/S	14.61** >fewer (less Cl.5)	67.05** >fewer

Variables	Cluster 1 'Symptoms'	Cluster 2 'Network'	Cluster 3 'Trauma'	Cluster 4 'Bereav't'	Cluster 5 'Helper'
Less Fearful	N/S	25.33** >fewer (less Cl.5)	N/S	6.88* >fewer (less Cl.5)	75.66** >fewer
Help Others	N/S	N/S	N/S	N/S	45.73** >fewer
Belonging	N/S	N/S	N/S	N/S	86.02** >fewer
Once Seen Professional	N/S	N/S	N/S	N/S	33.55** >fewer
Now Seeing Professional	N/S	7.21* >fewer	18.85** >more	N/S	N/S
Help non Professional	N/S	N/S	6.16** >more	N/S	5.33* >fewer
Once Taken Medication	N/S	26.41** >fewer (less Cl.5)	N/S	4.18* >fewer (less Cl.5)	44.86** >fewer
Now Taking Medication	N/S	16.0** >fewer	13.96** >more	4.71* >more	N/S
Expectation of Grow	N/S	4.28* >better than expected	N/S	N/S	10.74* >expected or worse (3.53** >expected)
Occupation	N/S	N/S	8.22* >3 than 1+2	N/S	4.32* >1 than 2+3

## **APPENDIX B**

**SCL-90-R Questionnaire**  
**Perceived Support Network Inventory**  
**Helping Process Questionnaire**  
**Social Support - Appreciation Scale**

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Derodatis, L. R. 1975 SCL-90-R Questionnaire





First name, last initial \_\_\_\_\_

Rate the extent to which you agree with the following statements by circling the appropriate numbers.

During times of stress:

	1	2	3	4	5	6	7
I seek this person out for support or help							
This person provides me with support or help when I ask							
I am satisfied with this person's support or help							

Place a check next to the categories of support you might expect to receive from this person during times of stress:

☐ a) Emotional Support
 ☐ c) Advice and Information
 ☐ e) Social Participation  
☐ b) Material Aid Support
 ☐ d) Physical Assistance

This person receives support from me during times of stress for him/her.

1	2	3	4	5	6	7
Almost Never		Sometimes		Usually		Almost Always

Generally speaking, I have serious conflicts with this person.

7	6	5	4	3	2	1
Almost Never		Sometimes		Usually		Almost Always

First name, last initial \_\_\_\_\_

Rate the extent to which you agree with the following statements by circling the appropriate numbers.

During times of stress:

	1	2	3	4	5	6	7
I seek this person out for support or help							
This person provides me with support or help when I ask							
I am satisfied with this person's support or help							

Place a check next to the categories of support you might expect to receive from this person during times of stress:

☐ a) Emotional Support
 ☐ c) Advice and Information
 ☐ e) Social Participation  
☐ b) Material Aid Support
 ☐ d) Physical Assistance

This person receives support from me during times of stress for him/her.

1	2	3	4	5	6	7
Almost Never		Sometimes		Usually		Almost Always

Generally speaking, I have serious conflicts with this person.

7	6	5	4	3	2	1
Almost Never		Sometimes		Usually		Almost Always

First name, last initial \_\_\_\_\_

Rate the extent to which you agree with the following statements by circling the appropriate numbers.

During times of stress:

	1	2	3	4	5	6	7
I seek this person out for support or help							
This person provides me with support or help when I ask							
I am satisfied with this person's support or help							

Place a check next to the categories of support you might expect to receive from this person during times of stress:

☐ a) Emotional Support
 ☐ c) Advice and Information
 ☐ e) Social Participation  
☐ b) Material Aid Support
 ☐ d) Physical Assistance

This person receives support from me during times of stress for him/her.

1	2	3	4	5	6	7
Almost Never		Sometimes		Usually		Almost Always

Generally speaking, I have serious conflicts with this person.

7	6	5	4	3	2	1
Almost Never		Sometimes		Usually		Almost Always

## HELPING PROCESS QUESTIONNAIRE

NAME OF GROUP.....

This is a list of things which may occur in your group meetings. The most important words in each statement have been underlined to try to make it clearer what we are getting at. Please read each statement carefully and then circle the number which best describes how it is for your group. This is the meaning of the numbers:

1	2	3	4	5
NOT AN ACCURATE DESCRIPTION (this is something that rarely happens; it is not at all like our group)	> > > >	SOMEWHAT ACCURATE DESCRIPTION (this happens, but not very often; it doesn't give a very good idea of what our group is like)	> > > >	VERY ACCURATE DESCRIPTION (this happens often; it gives a good idea of what our group is like).

In using this scale, circle the number to the right of the statement that is most nearly right for your group in your opinion. For example, if you read the statement "This group gives members support", and you decide that this happens now and then but it is not given a lot of importance in your group, you would probably circle the number "3" to the right of the statement. If this happened a bit more often and was given a bit more importance, you might circle "4" instead, and so on. Circle only one number for each statement. Don't worry over it and spend too much time; if you don't know, just make your best guess.

NOT  
ACCURATE > > > SOMEWHAT  
ACCURATE > > > VERY  
ACCURATE

When a personal problem is brought up by a group member, other group members suggest things which the person might do to overcome his or her difficulty. The group sometimes makes very direct suggestions, like "Try this and see what happens"

1 2 3 4 5

Members compare what they think about things with what other group members think. Where differences exist members change their beliefs so that gradually most members come to share and express similar attitudes.

1 2 3 4 5

Group members reassure other members that their problems will eventually be worked out positively.

1 2 3 4 5

Group members let other members know how they feel about them. This information is shared face to face.

1 2 3 4 5

## Page 2.

NOT ACCURATE > > > SOMEWHAT ACCURATE > > > VERY ACCURATE

The group has rules about how members should feel and think and act. Group members refer to these rules.

1 2 3 4 5

Group members tell each other about experiences, fantasies, thoughts and emotions which are very personal and which they wouldn't normally tell other people.

1 2 3 4 5

When a member tells other members that his or her emotional reactions to a problem are strange or abnormal, other members point out that such reactions are experienced by most people facing this problem. In other words, the group suggests that the person is reacting normally to a stressful situation.

1 2 3 4 5

Group members explain how they would handle a problem brought up by another member, and then go on to show just how they would react if they were faced with this person's problem.

1 2 3 4 5

A group member sets his or her goals and checks the progress made toward their achievement.

1 2 3 4 5

Members provide explanations which help other group members better understand themselves and their reaction to a situation.

1 2 3 4 5

When a member does something the group disapproves of, the group criticises this behaviour or in some way punishes the person acting in this way.

1 2 3 4 5

When a person expresses his or her emotions in the group, other group members let that person know that they share and understand their feelings

1 2 3 4 5

Page 3.

	NOT ACCURATE > > >		SOMEWHAT ACCURATE > > >		VERY ACCURATE
When a group member describes a situation happening at the present time as similar to situations which happened in their experience in the past other group members <u>point out in what ways these situations or emotional reactions are different.</u>	1	2	3	4	5
A group member <u>asks</u> other group members <u>how they feel about him or her.</u>	1	2	3	4	5
When a group member does something the group approves of, the group <u>applauds</u> this behaviour or in some way <u>rewards</u> the member for acting in this way.	1	2	3	4	5
Members assure one another that they are <u>worthwhile, valuable people.</u>	1	2	3	4	5
Group members <u>challenge one another to explain themselves</u> or account for their behaviour.	1	2	3	4	5
Group members try to understand a problem by <u>breaking it down</u> and finding out such things as what went on before the problem arose, how the person reacted to the problem, and what happened after the difficulty arose.	1	2	3	4	5
When a personal problem is brought up by a member, other group members suggest how the person might act to handle the problem, and then ask the person to <u>practise doing what is suggested in the presence of the group</u>	1	2	3	4	5
Group members <u>share everyday experiences</u> with one another and generally let each other know what's going on in their lives.	1	2	3	4	5

Page 4.

NOT ACCURATE > > > > SOMEWHAT ACCURATE > > > VERY ACCURATE

Members assure one another that they are capable of handling their own problems.

1 2 3 4 5

When a group member brings up a personal problem, other members ask the person for additional information about the problem, but do so in a way which is not threatening.

1 2 3 4 5

When a personal problem is brought up by a member, other group members identify actions which they believe are things which he or she should not do. The group may even make the direct suggestion: "Don't do this".

1 2 3 4 5

Members let other members know that they were justified in feeling or acting as they did in response to some situation.

1 2 3 4 5

After listening to a member discuss his or her concerns, members state in other words what they believe the person has said: they may also make some statements concerning how they believe he or she is feeling emotionally.

1 2 3 4 5

When a member says or does something of which the group disapproves, the group members ignore the person's behaviour.

1 2 3 4 5

The group puts importance on and encourages members to show their feelings.

1 2 3 4 5

## SOCIAL SUPPORT - APPRECIATION SCALE

Age \_\_\_\_\_

Sex: M F

Below are a list of statements about your relationships with your friends and family. Please indicate how much you agree or disagree with each statement as being true. Answer all items; if you are unsure, make your best guess.

	(circle one number in each row)			
	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
My friends respect me	1	2	3	4
My family cares for me very much	1	2	3	4
I am not important to others	1	2	3	4
My family holds me in high esteem	1	2	3	4
I am well liked	1	2	3	4
I can rely on my friends	1	2	3	4
I am really admired by my family	1	2	3	4
I am respected by other people	1	2	3	4
I am loved dearly by my family	1	2	3	4
My friends don't care about my welfare	1	2	3	4
Members of my family depend on me	1	2	3	4
I am held in high esteem	1	2	3	4
I can't rely on my family for support	1	2	3	4
People admire me	1	2	3	4
I feel a strong bond with my friends	1	2	3	4
My friends look out for me	1	2	3	4
I feel valued by other people	1	2	3	4
My family really respects me	1	2	3	4
My friends and I are really important to each other	1	2	3	4
I feel like I belong	1	2	3	4
If I died tomorrow, very few people would miss me	1	2	3	4
I don't feel close to members of my family	1	2	3	4
My friends and I have done a lot for each other	1	2	3	4

## **APPENDIX C**

Subject Interview Schedule  
Life Events Schedule  
SCL-90-R Questionnaire  
People In Your Life Questionnaire  
Life-as-a-Whole Single Item Questionnaire  
Satisfaction with Life Domains Scale  
Satisfaction with Life Scale  
Affect Balance Scale  
Mastery Scale  
Protocol for Phase 3 Interview  
Means and standard deviations for results from which  
graphs were constructed  
Summary description of subjects used to select control  
sample

### INTERVIEW SCHEDULE - PHASE III - SUBJECTS

Research Number \_\_\_\_\_ Date \_\_\_\_\_

Sex:      Male      Female      Age in years

**Marital status:**    **Married**    **Widowed**    **Single**    **Separated/Divorced**

Occupation

or Previous Occupation

or Breadwinner's Occupation

Number of dependants	Number of children
----------------------	--------------------

Education: - did not finish high school

- finished high school

- attended tertiary institution

- qualified at tertiary institution

- trade qualification

Do you live: - on your own

- with brothers/sisters/parents

- with spouse/partner/child or children

- with friends

- in a hostel etc

How long have you been in the GROW group? Two weeks or less; < 1 month;

< 3 months;      3 - 12 months;

1 - 2 years;    > 2 years.

Have you been in GROW before?    Yes    No

On the average, do you have contact with members of your GROW group other than during meetings:

Never;      < once a week;      at least once a week;

every day; > once a day.



Why did you join GROW? (As many as apply)

For help with - loneliness/isolation

- an unhappy relationship

- drinking or drug problems

- family problems

- physical problems

- unemployment/financial problems

- bereavement

- misery/depression

- recovery after hospitalisation

- uncontrolled feelings

- guilt

- anxiety/nervousness

- fear of strange places/people

- broken relationship

- a poor opinion of myself

- to help another person/people

- other reasons \_\_\_\_\_

\*How would you rate the helpfulness of GROW with the problems that brought you to GROW?

Extremely  
helpful

Rather  
helpful

Didn't make  
much difference

Things got  
worse

Made things  
much worse

What did the group do to help you? (as many as apply)

- made me feel less lonely
- helped me change my ways of acting
- gave me something to do
- helped me see others' point of view
- taught me to control my feelings by thinking
- helped me be less fearful
- taught me I could help others
- gave me a feeling of belonging
- nothing
- other \_\_\_\_\_

Have you sought help for your problems from helping professionals in the past?

Yes No

If yes, from whom? \_\_\_\_\_

\*Have you received professional help in the last two months? Yes No

\*If yes, from whom? \_\_\_\_\_

\*how often? \_\_\_\_\_

\*What changes, if any, have there been in the last two months in the professional help you receive?

\_\_\_\_\_

Have you ever been in hospital because of stress, nervous or mental problems?

Yes No \*In the past two months? Yes No

\*If yes, for how long? \_\_\_\_\_

In the past have you gone to other sources, other than professionals, for help with the problems that brought you to GROW?

Yes No

In yes, what sources? \_\_\_\_\_

Have you ever had prescribed medication to help you with stress, nervous or mental problems?

Yes      No

\*Do you take any such medication now?    Yes      No

\*If yes, do you know what medication? \_\_\_\_\_

\*Has your medication been changed in the last two months?

Increased      Decreased      Unchanged

\*Has any change been:    Your decision      Your doctor's

[\* To be repeated at four interviews]

## LIST OF RECENT EXPERIENCES (ex Heady 1985)

Check at each interview whether any of the following occurred in the last two months:

1	2	3	4

- You or your family became much better off financially
- You had a major financial crisis
- You had continuous financial worry
- You were unemployed or seeking work
- Continuing risk of being laid off or made redundant
- Sacked or laid off
- Your own business failed
- You were promoted
- You found out you were not going to be promoted
- Trouble or arguments with people at work or other difficulties


- You had a serious illness or injury
- You had a serious accident (e.g. car accident)
- You took more exercise and your fitness improved a lot
- You took less exercise and your fitness worsened a lot


- You became engaged
- You broke off an engagement
- You were married
- You separated from your husband/wife
- Husband and wife got together again after separation
- You divorced
- Your husband/wife began an extra-marital affair
- You experienced some sexual difficulties


- You took up a new spare time activity
- You joined an organisation or club for a spare time activity
- You stopped a spare time activity which you used to enjoy
- You left an organisation or club for spare time activity
- You passed an important exam or had other important successes in your studies
- You failed an important exam or had other important failures in your studies
- You took an educational course and felt you had really increased your knowledge and skills
- Courses or studies seemed pointless


- Your husband/wife died
- A child or yours died
- A close family members died, not including spouse or own child
- You/your wife had an abortion, miscarriage or still-birth
- Serious problems or arguments with one or more of your children
- Behaviour of one of your parents/ parents-in-law was a serious problem
- Behaviour of one of your brothers/sisters was a serious problem


- A friendship with someone of the same sex became much closer
- A friendship with someone of the same sex worsened or split up
- A close friend died
- You made lots of new friends


- You were robbed
- You were physically assaulted
- You had problems with the police leading to a court appearance
- You had a prison sentence
- You had a civil suit


- You experienced a religious conversion
- You became much more actively involved in a church or religious organisation
- You lost your religious faith

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Research number \_\_\_\_\_

Date \_\_\_\_\_

**INSTRUCTIONS: READ EACH QUESTION CAREFULLY AND THEN ANSWER EACH PART OF EACH QUESTION.**

### Section A: Acquaintances and Friends

1. How many people from work do you see socially evenings or weekends?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one item below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

2. How many neighbors do you socialize with (for example, have over for a meal or a party, go to a movie with, etc.)?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one item below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

3. Apart from contacts with people at work and in your neighborhood, how many acquaintances whom you know casually do you have contact with in an ordinary week?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one item below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

4. How many people with similar interests to you do you have contact with (for example, interests in sports, music, political activity, etc.)?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

5. How many friends do you have who could come to your home at any time and take things as they find them (for example, they wouldn't be embarrassed if the house was untidy or if you were in the middle of a meal)?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

6. How many friends do you have whom you could visit at any time without waiting for an invitation?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

7. How many friends do you have that are part of a group of people who see a lot of each other and that you keep in close touch with?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

8. How many friends do you have whom you could turn to when you are in trouble and need help?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

9. How many people are there who really appreciate what you do for them?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

10. How many people are there who depend on you to care about them, provide help and/or offer guidance in day-to-day life?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

11. How many people are there who are immediately available to you, with whom you can talk openly without having to watch what you say?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

12. If something unpleasant or irritating happens and you get upset or angry about it, how many people are there whom you can go to and tell them just how you feel?

Check one of the boxes.

None 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Now check one of the items below to indicate how this suits you.

(If you have checked the box labeled "None" above, indicate how you feel about not having anyone by checking one item below.)

\_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

### Section B: Persons Who Are the Most Important to You

13. How many people are available to you whom you consider to be the most important in your life?

Check one of the boxes.

None 1 2 3 4 5 or more

☐ ☐ ☐ ☐ ☐ ☐

List below the names of these people. Opposite each name you list, indicate whether that person is your spouse, father, mother, son, daughter, brother, sister, sexual partner, other relative, or any other category of relationship.

a) List first names only:

b) Relationship:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

20. When you don't feel like doing things that need to get done because you are feeling too upset about something, which of the persons you listed in item 13 could you call on to help out (List first names only)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Now check one item below to indicate how this suits you.

(If you have not listed anyone, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

21. When something happens to you that has never happened to you before, which of the people you listed in item 13 could you go to to get help in understanding what is happening to you, and to get help in feeling less confused (List first names only)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Now check one item below to indicate how this suits you.

(If you have not listed anyone, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

22. When you are happy, which of the people you listed in item 13 could you share your pleasure with, i.e., persons who will feel happy simply because you are (List first names only)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Now check one item below to indicate how this suits you.

(If you have not listed anyone, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied

23. Considering the people you listed in item 13, do you expect to have lasting relationships with any one of them, i.e., you intend to go on sharing your life with (List first names only)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Now check one item below to indicate how this suits you.

(If you have not listed anyone, indicate how you feel about not having anyone by checking one item below.)

- \_\_\_\_\_ very satisfied  
 \_\_\_\_\_ some improvement desired  
 \_\_\_\_\_ a lot of improvement desired  
 \_\_\_\_\_ very dissatisfied



## LIFE-AS-A-WHOLE SINGLE ITEM QUESTIONNAIRE

A. Research number \_\_\_\_\_ Date \_\_\_\_\_



Which face comes closest to expressing how you feel about life as a whole?

RESEARCH NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

Tick a square to show which face you choose  
for each question.



1. Which face comes closest to expressing how you feel about your house/flat/place of residence?							
2. Which comes closest to expressing how you feel about this particular neighbourhood as a place to live?							
3. Which comes closest to expressing how you feel about the food you eat?							
4. Which face comes closest to expressing how you feel about the clothing you wear?							
5. Which comes closest to expressing how you feel about your health?							
6. Which face comes closest to expressing how you feel about the people you live with?							
7. Which comes closest to expressing how you feel about your friends?							
8. Which comes closest to expressing how you feel about your relationship with your family?							
9. Which comes closest to expressing how you feel about how you get on with other people?							
10. Which comes closest to expressing how you feel about your job/work/day programming?							
11. Which face comes closest to expressing how you feel about the way you spend your spare time?							
12. Which comes closest to expressing the way you feel about what you do in the community for fun?							
13. Which comes closest to expressing how you feel about the services and facilities in this area?							
14. Which comes closest to expressing how you feel about your economic situation?							
15. Which comes closest to expressing how you feel about the place you live now, compared with hospital?							

## SATISFACTION WITH LIFE SCALE

DIENER

Research number \_\_\_\_\_

Date \_\_\_\_\_

Below are five statements with which you may either agree or disagree. Using the scale 1 to 7, indicate your agreement by circling the number which corresponds most closely to your opinion. Please be open and honest in your response.

Scale: 1 = strongly disagree  
 2 = disagree  
 3 = slightly disagree  
 4 = neither agree or disagree  
 5 = slightly agree  
 6 = agree  
 7 = strongly agree

In most ways my life is close to my ideal	1	2	3	4	5	6	7
The conditions of my life are excellent	1	2	3	4	5	6	7
I am satisfied with my life	1	2	3	4	5	6	7
So far I have got the important things I want in life	1	2	3	4	5	6	7
If I could live my life over I would change almost nothing	1	2	3	4	5	6	7

## AFFECT BALANCE SCALE

BRADBURN

Research number \_\_\_\_\_

Date \_\_\_\_\_

During the past two months have you ever felt:

Particularly excited or interested in something? Yes \_\_\_\_\_ No \_\_\_\_\_

Proud because someone complimented you on  
something you had done? Yes \_\_\_\_\_ No \_\_\_\_\_

So restless that you couldn't sit long in a chair? Yes \_\_\_\_\_ No \_\_\_\_\_

Very lonely or remote from other people? Yes \_\_\_\_\_ No \_\_\_\_\_

Pleased about having accomplished something? Yes \_\_\_\_\_ No \_\_\_\_\_

On top of the world? Yes \_\_\_\_\_ No \_\_\_\_\_

Bored? Yes \_\_\_\_\_ No \_\_\_\_\_

Depressed or very unhappy? Yes \_\_\_\_\_ No \_\_\_\_\_

Upset because someone criticised you? Yes \_\_\_\_\_ No \_\_\_\_\_

That things were going your way? Yes \_\_\_\_\_ No \_\_\_\_\_

## MASTERY SCALE

PEARLINS

Research number \_\_\_\_\_

Date \_\_\_\_\_

Circle the number that is closest to your view

	Strongly disagree	Disagree	Agree	Strongly agree
I have often found that what is going to happen will happen regardless of my actions.	1	2	3	4
Becoming a success is a matter of hard work; luck has little or nothing to do with it.	1	2	3	4
Most people don't realise the extent to which their lives are controlled by accidental happenings	1	2	3	4
I can do just about anything I really give my mind to.	1	2	3	4
The average citizen can have an influence in government decisions.	1	2	3	4
It is impossible for me to believe that chance or luck plays an important role in my life.	1	2	3	4
This world is run by a few people in power, and there is not much the little person can do about it.	1	2	3	4
Sometimes I feel that I don't have enough control over the direction my life is taking.	1	2	3	4

### **Protocol for initial interview: Phase 3**

"This is part of our ongoing research project to see what differences we can detect between people who are GROW members attending GROW meetings and others who might be but choose not to be GROW members.

"To do this we want to ask you a series of questions on four separate occasions about eight weeks apart. Each session will take about an hour or an hour and a half and we will arrange a time and place that suits you. Anything you tell us will be treated with the strictest confidence: I will be the only person who will know your name and address and all of your information will be identified by a research number only. It is not our intention to pry into your affairs: we are interested to know what difference GROW membership makes in people's lives generally, not to know facts about any individual. [Produce Research Participant Card]. This will be your number of purposes of our research, so don't put your name on any of the papers: just this number. And if you keep your card, we'll use the same number at each of our meetings.

"Some of the questions I will ask you and some you will do with a pencil and paper. The questions we will ask are of four kinds.

"First, there's some detail which we'll only have to get once: things like whether you're married, what your occupation is, whether you live in a family or by yourself and so on. We will also need to know about any major event that happens between our meetings so I will check that out each time we meet.

"Secondly, there's a questionnaire which asks questions about things that may have been troubling you and is some measure of your mental health.

"Thirdly, there are some questions about how you get along with your family and friends -- what we call your social network and social support.

"And fourthly, there are general questions about how you find various aspects of your life. In fact I might ask you a question about that now."  
 [Show L-W card: Which face comes closest to expressing how you feel about your life as a whole]

[Phase 1 questionnaire is filled out with S]

[LES checked off, reading it out]

[SCL-90-R introduced: research number only at head]

[ABS, read out]

[PIYL; S marks answers, interviewer assists]

[SWL scale, S completes]

[MS scale, interviewer reads and marks]

[SLDS, S completes]

"Now that you've spent that last hour or so thinking about various aspects of your life, how would you answer this question we started with:" [Produce a fresh copy of L-W card].



Means from which Figures 2 to 5e were constructed, together with standard deviations.

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**SCL90-R**

Som	M	43.556	41.833	42.144	37.522
	SD	23.042	23.409	23.463	27.840
Phob	M	34.033	32.656	26.622	24.500
	SD	32.386	32.599	32.389	31.196
Psy	M	47.589	39.500	38.667	33.067
	SD	28.130	30.877	30.184	30.829
PST	M	52.648	51.923	51.264	49.451
	SD	10.462	10.958	8.771	13.365

---

**PIYL INAV**

Total	M	2.535	2.337	2.567	2.412
	SD	2.984	1.104	1.284	1.145
Regular	M	2.398	2.571	2.890	2.643
	SD	1.173	1.114	1.231	1.007
Irregular	M	2.865	1.769	1.785	1.854
	SD	5.269	0.862	1.070	1.281

---

**PIYL INSAT**

Total	M	-0.084	-0.027	0.010	0.063
	SD	0.553	0.466	0.539	0.469
Regular	M	-0.110	-0.021	0.090	0.102
	SD	0.576	0.460	0.370	0.320
Irregular	M	-0.018	-0.043	-0.193	-0.033
	SD	0.494	0.487	0.799	0.722

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**PIYL FAV**

Total	M	3.349	2,934	2.930	2.951
	SD	1.633	1.487	1.509	1.408
Regular	M	3.544	3.198	3.276	3.321
	SD	1.571	1.524	1.478	1.330
Irregular	M	2.868	2.286	2.079	2.041
	SD	1.714	1.183	1.244	1.179

---

**PIYL FSAT**

Total	M	-0.035	-0.040	0.015	0.053
	SD	0.360	0.340	0.332	0.258
Regular	M	-0.004	0.006	0.063	0.090
	SD	0.366	0.310	0.243	0.207
Irregular	M	-0.109	-0.153	-0.104	-0.039
	SD	0.340	0.387	0.473	0.341

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**L-W**

Total	M	3.085	2.621	2.692	2.582
	SD	1.146	1.184	1.271	1.121
Regular	M	2.942	2.477	2.508	2.415
	SD	1.089	0.894	1.091	0.998
Irregular	M	3.442	2.981	3.154	3.000
	SD	1.227	1.676	1.567	1.311

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**ABS**

Total	M	0.044	0.711	1.111	0.767
	SD	1.965	2.078	2.041	1.885
Regular	M	0.138	0.985	1.400	1.092
	SD	1.999	1.916	1.894	1.934
Irregular	M	-0.200	0.000	0.360	-0.080
	SD	1.893	2.345	2.252	1.470

---

**SWL**

Total	M	15.231	17.593	19.934	21.308
	SD	6.610	6.556	6.909	6.624
Regular	M	15.662	18.723	20.846	22.200
	SD	6.833	6.161	6.775	5.940
Irregular	M	14.154	14.769	17.654	19.077
	SD	6.005	6.778	6.887	7.771

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**SLDS**

Total	M	45.363	47.978	50.187	50.835
	SD	11.687	12.217	12.713	11.731
Regular	M	46.646	49.323	51.846	52.600
	SD	10.435	10.217	10.247	10.181
Irregular	M	42.154	44.615	46.038	46.423
	SD	14.070	15.925	16.969	14.202

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**MS**

Total	M	19.989	20.467	21.000	21.322
	SD	2.709	3.353	3.006	2.664
Regular	M	20.138	20.923	21.323	21.661
	SD	2.850	2.896	2.900	2.527
Irregular	M	19.600	19.280	20.160	20.440
	SD	2.309	4.158	3.171	2.859

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## Summary Description of Subjects

Female, 55, married, 2 grown children, lives with husband and one child, self-employed florist: depressed, lonely, impoverished marriage.

Female, 43, separated, no children, lives with friends, unemployed former dental assistant: depressed after late marriage failed.

Female, 40, separated, 4 children, lives with young children, former nurse aide: lonely, depressed.

Male, 36, single, lives alone, former labourer on pension: depressed, lonely, alcohol problems.

Male, 37, separated, no children, lives alone, teacher: depressed, anxious after broken relationship.

Male, 33, single, lives with father and siblings, fencing contractor: depressed, lonely, low self esteem.

Male, 39, single, lives alone, former taxi driver on pension: schizophrenic on Modecate.

Female, 60, married, 3 grown children, lives with alcoholic husband: anxious, on minor tranquillizers.

Female, 31, married, 1 infant, formerly child welfare officer, husband a professional engineer (?) and well-off: manic depressive on Lithium.

Female, 36, single, lives in country with friends, former teacher: schizophrenic on Fluphenazine.

Male, 34, single, lives alone, gardener: lonely, depressed, anxious.

Female, 36, single, former clerk, lives with parents: schizophrenic on major tranquillizers.

Female, 20, single, nurse aide, lives with friends: depressed, relational problems.

Male, 56, single, taxi driver, lives alone: lonely, depressed, anxious, hospitalised for breakdown years ago.

Male, 41, council worker, married, 4 school children, lives in country town with family, into alternative medicine: very anxious, low self esteem.

Female, 22, single, bank clerk, lives with friends: lonely, anxious, depressed, low self esteem.

Female, 42, married to a labourer, 2 children living at home: family problems, son on drugs, anxious, low self esteem.

Female, 34, married with 2 school children, articulate: long-standing bulimia.

Male, 34, divorced, 1 child, lives with sister in provincial town: schizophrenic on Modecate.

Female, 26, single, housemaid/child care worker, lives at home: lonely, anxious, PMT.

Female, 45, separated, factory hand, five children at home: relational problems, anxious, low self esteem, on minor tranquillizers.

Male, 40, in second marriage, school caretaker, 2 children: broken relationship, low self esteem, anxious.

Male, 39, single, clerk, lives alone: lonely, depressed.

Male, 33, single, lives alone, electronic technician: schizophrenic and major tranquillizers.

Male, 47, divorced, lives alone, former storeman on pension: anxious, ex-alcoholic.

Male, 25, single, lives with friends, barman: alcoholic on minor tranquillizers.

Male, 36, single, artist/poet, lives alone: lonely, schizophrenic on major tranquillizers.

Male, 54, married with three children, lives with wife and one child: depressed after incapacitating physical illness.

Male, 32, single, lab technician, lives alone: lonely, schizophrenic on Modecate.

## **APPENDIX D**

### **Published papers**

These articles have been removed for  
copyright or proprietary reasons.

- Young, J. Williams, C.L. (1987). An evaluation of GROW, a mutual-help community health organisation. *Community health studies*, XI, 1, 38-42
- Young, J. Williams, C.L. (1988). Whom do mutual-help groups help? A typology of members. *Hospital and community psychiatry*, 39, 11, 1178-1182
- Young, J. Williams, C.L. (1989). Group process and social climate of GROW, a community mental health organisation. *Australian and New Zealand journal of psychiatry*, 23, 1, 117-123
- Young, J. (1990). An Outcome evaluation of GROW, a Community central health movement. *NEC*, 249-254
- Young, J. (1990). Evaluating the effectiveness of membership of a mutual help organisation. *Network*, 6, 37-43